

128006

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 2 1 6 4

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Winnifred Cecelia Schwehr AAVEDAL			2a. DATE OF DEATH MONTH DAY YEAR April 28, 1985		2b. HOUR 3:30pm
3. SEX Female	4. RACE Cauc.	5. DATE OF BIRTH MONTH DAY YEAR Oct. 4, 1907		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N. Dakota	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.	
10. CITY OR TOWN OF DEATH Lanham	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Doctors' Hospital of Pr. Geo. Co.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Dry Cleaning	12b. KIND OF BUSINESS OR INDUSTRY Self Employed	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY Montana Helena			13b. CITY OR TOWN Helena	13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13d. STREET ADDRESS ZIP CODE 720 North Washington Ave 20706
FATHER'S NAME FIRST MIDDLE LAST Cosmos Schwehr		MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Cecilia Diemert		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No	
16b. SOCIAL SECURITY NO. 516-20-7107		17. INFORMANT Myrna Aavedal		ADDRESS 6814 Storch Ct. Lanham, Md. 20706	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) **subdural hematoma, recent, massive**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 10:00 P.M. 4-27-85		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) Fell on stairway	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) Home		21f. LOCATION CITY OR TOWN COUNTY STATE 6814 Storch Court, Lanham Pr. George's	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (the doctor) saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Jerry B. Harmon, MD		DEGREE Pathologist		22c. DATE SIGNED 4-29-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jerry B. Harmon		22e. ADDRESS 5115 Good Luck Rd Lanham, MD			

MEDICAL CERTIFICATION

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE May 3, 1985	23c. NAME OF CEMETERY OR CREMATORY Resurrection Cem.	23d. LOCATION CITY OR TOWN COUNTY STATE Helena Montana
24. FUNERAL DIRECTOR NAME Howard Hales Lanham F.H.		25a. DATE RECD. BY REGISTRAR APR 30 1985	25b. REGISTRAR'S SIGNATURE [Signature]

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DEBIL MOTION FOR



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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

120013

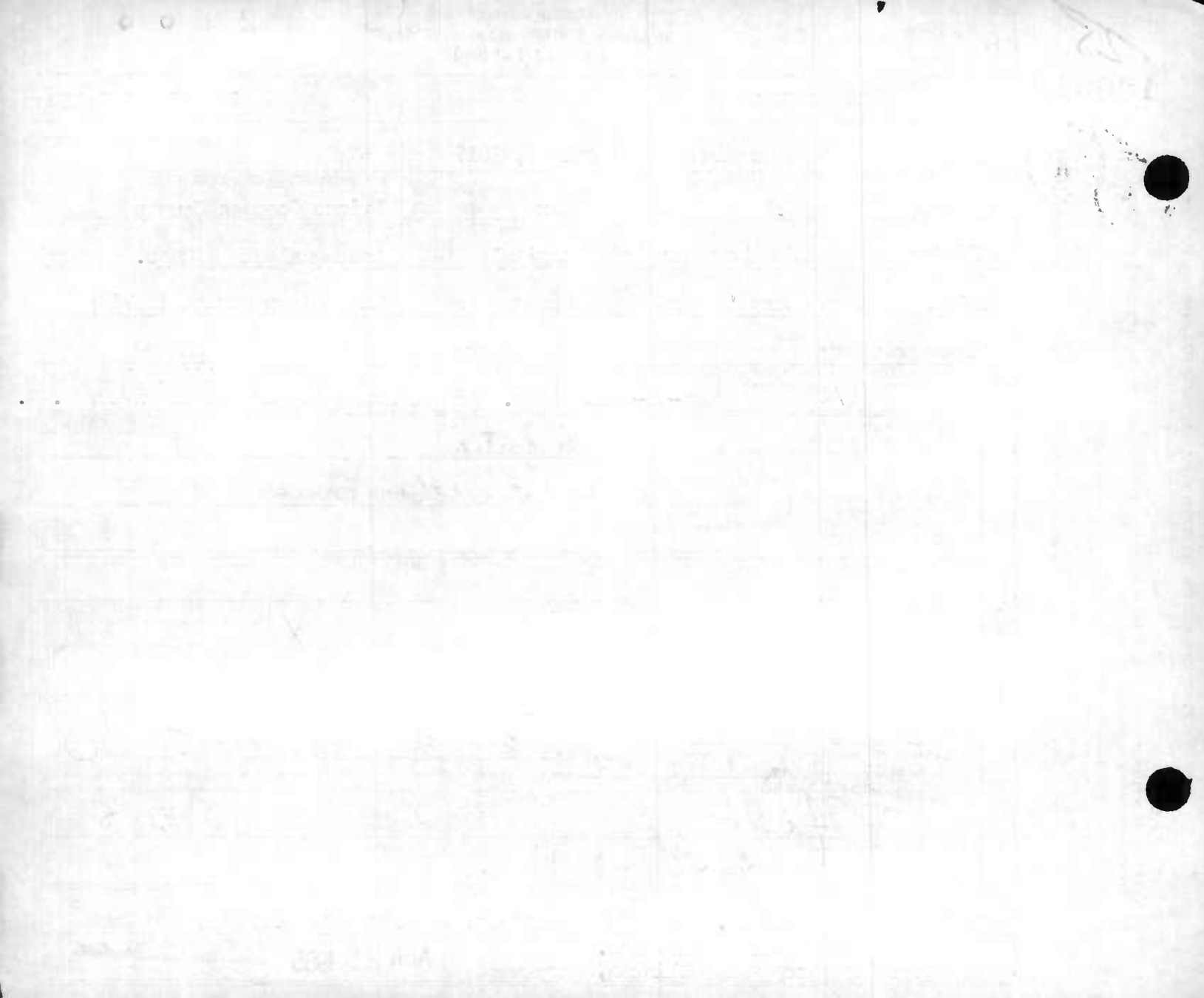
1. DECEASED NAME (TYPE OR PRINT) Sari Ackerman		2a. DATE OF DEATH MONTH 4 DAY 23 YEAR 85		2b. HOUR 7:23 PM	
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH July DAY 7 YEAR 1917		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges County MD.	
10. CITY OR TOWN OF DEATH Clinton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Maryland Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cost Analyst		12b. KIND OF BUSINESS OR INDUSTRY Dept. of Navy
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Prince George's 13c. CITY OR TOWN Marlow Heights			13d. INSIDE CITY LIMITS? NO		13e. STREET ADDRESS / ZIP CODE 2224 Olson Street (20748)
14. FATHER'S NAME FIRST Meyer MIDDLE Kosofsky LAST			15. MOTHER'S MAIDEN NAME FIRST Mary MIDDLE Unknown LAST		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT ADDRESS 20 Hidden Glen Road Dr. Neil Ackerman Upper Saddle River, N. J.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>inaction</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>metastatic colon cancer</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. <u>NO</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 84</u> to <u>April 23 85</u> , that (I) (we) last saw the deceased alive on <u>April 23 85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>[Signature]</i>		DEGREE		22c. DATE SIGNED <u>4/24/85</u>	
22d. PHYSICIAN'S NAME (LAST OR PRINT) HAIDAK MD		22e. ADDRESS Clinton Md			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE April 25, 1985		23c. NAME OF CEMETERY OR CREMATORY New Montefiore Cemetery Farmingdale, New York	
23d. LOCATION CITY OR TOWN COUNTY STATE		23e. DATE REC'D. BY REGISTRAR			
24. FUNERAL DIRECTOR NAME Lee Funeral Home, Inc. ADDRESS 1663 Old Alexander Ferry Road, Clinton, Maryland		25a. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 18 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



114039

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

1 2 1 6 6

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		George Washington Allen		2a. DATE KNOWN OF DEATH		April 13 1980		2b. HOUR		2:00	
1. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	7. UNDER 1 YR.	8. UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD		April 13 1980		2d. HOUR	
Male	White	02 04 1896	89								
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Virginia		U.S.A.				Prince George's County MD					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Riverdale		Leland Memorial Hospital		Carpenter		Building					
13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13d. STREET ADDRESS					
Maryland		P.G.		Hyattsville		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3706 Oliver Street		20782	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
James Nathaniel Allen		Annie Virginia Ruby		Yes		W.W.I		Maxine Miller (Daughter)		3706 Oliver St. Hyattsville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART 1 DEATH WAS CAUSED BY:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
2880		IMMEDIATE CAUSE (a) Respiratory Arrest									
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.		(b) Pneumonia & Pleural Effusion									
		(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1		Fracture L. hip									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?							
3-880		Fracture L. hip		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
		HOUR A.M. MONTH DAY YEAR		Fall at home							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION							
		Home		Oliver St. Hyattsville, Prince Georges							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from:		Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> .		TITLE (SPECIFY)							
ACTUAL SIGNATURE		M.D. Depri		MEDICAL EXAMINER		DATE SIGNED April 14 1980					
EXAMINER'S NAME (TYPE OR PRINT)		John S. Rogers, M.D.		ADDRESS		1919 Seminary Rd. Silver Spring, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		COUNTY		STATE	
Burial		4/17/85		Mount Herman Cemetery		Mt. Jackson		Shenandoah Va.			
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Francis Gasch's Sons Funeral Home, P.A.		APR 18 1985		Rendell							
4739 Baltimore Avenue Hyattsville, Md. 20781											

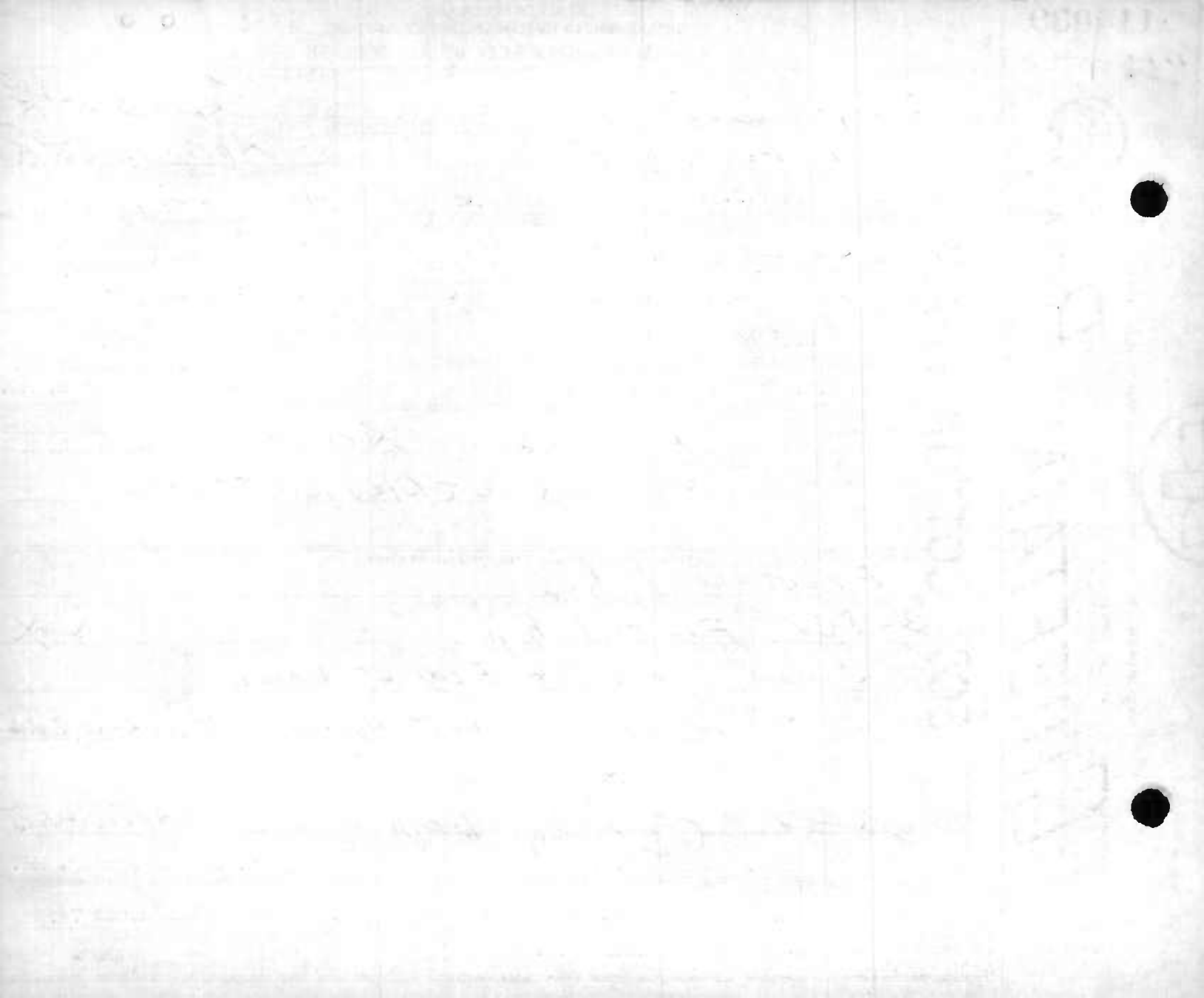
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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1209351- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST KATHERINE A. AMMANN			2a. DATE OF DEATH MONTH DAY YEAR 4-19-85			2b. HOUR 5:30P M	
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR 8 27 1953		6. AGE (IN YEARS LAST BIRTHDAY) 31 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MASS.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES CO. MD.	
10. CITY OR TOWN OF DEATH LAUREL		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GREATER LAUREL BELTSVILLE HOSP.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD.				13b. COUNTY MONT.		13c. CITY OR TOWN BURTONSVILLE	
14. FATHER'S NAME FIRST MIDDLE LAST FREDERICK J. SULLIVAN				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LOUISE H. THOMPSON			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 19-46-9973		17. INFORMANT ADDRESS HAL AMMANN SAME AS 13E	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure DUE TO, OR AS A CONSEQUENCE OF (b) Disseminated Herpes simplex virus DUE TO, OR AS A CONSEQUENCE OF (c) Acquired Immunodeficiency Syndrome PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Disseminated M. avium-intercellulare						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 5th month 19 84 to 4/19 19 85, that (I) (we) last saw the deceased alive on 4/19 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.						22c. DATE SIGNED 4-19-85	
22a. SIGNATURE GREGORY A. COMPTON MD		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4-19-85	
22a. PHYSICIAN'S NAME (TYPE OR PRINT) GREGORY A. COMPTON MD		22e. ADDRESS 7601 SANDY SPR. RD. LAUREL, MD 20707		22c. DATE SIGNED 4-19-85			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 4-22-85		23c. NAME OF CEMETERY OR CREMATORY BALTO. WASH. CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE LAUREL PG. MD.	
24. FUNERAL DIRECTOR NAME FLECK FUNERAL HOME INC.		ADDRESS 7601 SANDY SPR. RD. LAUREL, MD 20707		25a. DATE REC'D. BY REGISTRAR APR 23 1985		25b. REGISTRAR'S SIGNATURE J. Davidson	

MEDICAL CERTIFICATION

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



130022

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1 2 1 6 8

1. DECEASED NAME (TYPE OR PRINT) Ruth Elinar Anthony			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 4-23-85		2b. HOUR 9A
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR April 28, 1917	6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN	2c. DATE PRONOUNCED DEAD 4-23-85
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County		10. CITY OR TOWN OF DEATH Kettering			
11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 72 Herrington Drive		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. STATE Pennsylvania		13b. COUNTY Westmoreland		13c. CITY OR TOWN Irwin	
14. FATHER'S NAME FIRST MIDDLE LAST Lester Hazel		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Black			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 209-30-1290		17. INFORMANT ADDRESS 72 Herrington Dr. Mr. Allen Baughman Kettering, Maryland	
18. CAUSE OF DEATH (Enter only one cause, and line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Debatable cardiac failure due to congestive heart failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE Augusto P. Rodriguez		TITLE (SPECIFY) Reguly		DATE SIGNED Apr/23, 1985	
EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez, M.D.		ADDRESS 5009 Rayburn Court Camp Springs, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4-26-85		23c. NAME OF CEMETERY OR CREMATORY Brush Creek Cemetery	
24. FUNERAL DIRECTOR NAME F. Gasch's Sons F.H. P.A.		ADDRESS Hyattsville, Maryland		25a. DATE REC'D. BY REGISTRAR MAY 8 1985	
25b. REGISTRAR'S SIGNATURE W. Landon Hordell					

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

106146

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF ESTI. DEATH MATED		MONTH		DAY		YEAR		2b. HOUR					
Walter						Arnolds, JR		4-6		19		85				M					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR		7d. HOUR	
Male		Black		Feb. 1, 1936		49 YRS.						4-8		19		85				M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH															
Georgia		USA				Prince George's														MD	
11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY																	
Camp Springs 6804 Robinia Road		Computer Analyst																			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS													
Maryland		P.G.		Camp Springs		YES		6804 Robinia Road													
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST											
Walter				Arnolds, Sr.		Unknown															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS																	
yes		258 48 3603		Mrs. Virginia Arnolds-wife-6804 Robinia Road, Camp Springs, Md.																	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio myopathy</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____																					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE																	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																					
ACTUAL SIGNATURE <u>Augusto P. Rodriguez</u>		EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez, M.D.		TITLE (SPECIFY) Deputy		MEDICAL EXAMINER		DATE SIGNED 4-8-85													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE April 12, 1985		23c. NAME OF CEMETERY OR CREMATORY Cheltenham National Cemetery, Cheltenham, Md		23d. LOCATION CITY OR TOWN COUNTY STATE															
24. FUNERAL DIRECTOR NAME <u>John T. Stewart</u>		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE																	
Stewart Funeral Home-4001 Benning Road, N.		APR 11 1985																			

07/84
25M

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DHMH - 17
(VR A15 ME (5))

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE
EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR.
PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS
AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET,
BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH			KNOWN ESTIMATED			MONTH DAY YEAR			2b. HOUR												
Carl Ellis Arthur						4 7 19 85			<input checked="" type="checkbox"/>						M												
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH DAY YEAR		2d. HOUR													
Male		Black		May 6, 1977		7 YRS.				4 7 19 85				10:50		P M											
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH															
Washington, D.C.				United States								Prince George's County, MD.															
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS															
Oxon Hill				Oxon Cove				Student/Friendship Center																			
13a. STATE				13b. CITY OR TOWN				13c. INSIDE CITY LIMITS?				13e. STREET ADDRESS															
D.C.				Washington				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				Apt. -B, (20032) 4184 Livingston Road, S.E.															
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME																							
Carl Arthur				Diane Vercinia Smith																							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS															
No				n/a				4184 Livingston Road, S.E. #B				Diane V. Arthur (mother) Washington, DC															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART I DEATH WAS CAUSED BY:																											
IMMEDIATE CAUSE (a) <u>Drowning</u>																											
DUE TO, OR AS A CONSEQUENCE OF																											
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.																											
(b) _____																											
DUE TO, OR AS A CONSEQUENCE OF																											
(c) _____																											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I																											
<u>Blunt trauma to head</u>																											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?															
												YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>															
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)																			
				HOUR A.M. MONTH DAY YEAR				Subject assaulted & thrown in cove																			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION				CITY OR TOWN				COUNTY				STATE							
				cove				Oxon Cove				Oxon Hill, P.G. CO, MD.															
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> .																											
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE																			
				Assistant				4/8/85																			
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS																							
Gregory R. Kauffman, M.D.				111 Penn St. Balto.M.D.																							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION				CITY OR TOWN				COUNTY				STATE			
Burial				04/13/85				Lincoln Memorial				Suitland, P.G. CO., Maryland															
24. FUNERAL DIRECTOR				25. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE																			
LATNEY's Funeral Home				APR 18 1985																							
3831 Georgia Ave. NW, Washington, DC 20011																											

PHMH - 17
(VR A15 ME (5))

11111



130020

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) WILLIAM R. ARTHUR			2a. DATE OF DEATH MONTH DAY YEAR 04-28-85		2b. HOUR 5 25PM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 11 19 1902		
6. AGE (IN YEARS LAST BIRTHDAY) 82		7. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD.				
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S GENERAL HOSP.		12. USUAL OCCUPATION (LAST OF WORKING LIFE) Carpenters Assistant		
13a. STATE Maryland		13b. COUNTY P.G.		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Samuel W. Arthur		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Minnie Ogden				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 230-03-2707		17. INFORMANT ADDRESS Rose B. Woodyard (Sister) 6121 Central Avenue Capitol Hgts., Md.		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Staphylococcal sepsis</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carbuncle with cellulitis, neck</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Diabetes mellitus</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>1-2 wks</u> <u>1-2 wks</u>
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Renal + respiratory failure

19a. DATE OF OPERATION <u>None</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>NA</u> <u>NA</u> <u>19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) <u>NA</u>			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <u>NA</u>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <u>NA</u> <u>NA</u> <u>NA</u> <u>NA</u>			
22a. I certify that (I) (this hospital) attended the deceased from <u>4/22/85</u> 19 <u>85</u> to <u>4/28/85</u> 19 <u>85</u> , that (I) (we) lost saw the deceased alive on <u>4/28</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>C. Soriano Jr. MD</u>		DEGREE <u>MD</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>4/29/85</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>CESAR SORIANO JR.</u>		22e. ADDRESS <u>119 CAPITOL HEIGHTS BLVD</u> <u>Capitol Hgts., Md. 20743</u>					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/3/85		23c. NAME OF CEMETERY OR CREMATORY Meads Memorial Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Madison Heights Amherst Virginia	
24. FUNERAL DIRECTOR Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue Hyattsville, Md. 20781				25a. DATE REC'D. BY REGISTRAR MAY 8 1985		25b. REGISTRAR'S SIGNATURE <u>Gina Davidson-Randall</u>	

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1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Harvey Junior ATKINS						2a DATE OF DEATH MONTH DAY YEAR April 18, 1985				2b HOUR 2:20A M	
3 SEX Male		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 4 1925		6 AGE (IN YEARS LAST BIRTHDAY) 59 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS.		IF UNDER 24 HRS HOURS MIN. YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD					
10. CITY OR TOWN OF DEATH Lanham		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Doctors' Hospital of Pr. Geo. Co.				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Repairmen		12b KIND OF BUSINESS OR INDUSTRY Radio			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a STATE Maryland		13b COUNTY Anne Arundel		13c CITY OR TOWN Gambrills		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 2335 Mt. Tabor Road 21054			
14 FATHER'S NAME FIRST MIDDLE LAST Walter Atkins						15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nannie Sutphin					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 225-22-4130		17 INFORMANT Ruth Jarrells		ADDRESS 2335 Mt. Tabor Road Gambrills, Md. 21054					
18 CAUSE OF DEATH (Enter only one cause per line for 1a), 1b), and 1c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive right lobar DUE TO, OR AS A CONSEQUENCE OF (b) hemorrhage with pleuralis - DUE TO, OR AS A CONSEQUENCE OF (c) diffusion - fatty liver & spleen Conditions, if any, which gave rise to immediate cause 1a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: 1a											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)							
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE							
22a I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____. That (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.											
22b SIGNATURE [Signature] DEGREE PHYSICIAN MEDICAL STAFF PHYSICIAN						22c DATE SIGNED 4/18/85					
22d PHYSICIAN'S NAME (TYPE OR PRINT) Monira Rifaat, M.D., Pathologist						22e ADDRESS Doctors' Hospital of Pr. Geo. Co. 8118 Good Luck Road, Lanham, Md. 20706					
23a BURIAL, CREMATION, REMOVAL Burial		23b DATE 4-22-85		23c NAME OF CEMETERY OR CREMATORY Mt. Comfort		23d LOCATION CITY OR TOWN COUNTY STATE Alex. Fairfax, Virginia					
24 FUNERAL DIRECTOR NAME ADDRESS Cunningham Funeral Home, Inc. P.O. Box 65 Alex. Va 22313						25a DATE REC'D. BY REGISTRAR APR 23 1985		25b REGISTRAR'S SIGNATURE [Signature]			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

1509308

2024 COLTON 11425



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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Willie J. Austin			2a. DATE OF DEATH MONTH DAY YEAR 04/ 26/ 1985		2b. HOUR 9:20a M		
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR Dec 15 1899		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.	
10. CITY OR TOWN OF DEATH Riverdale		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Leland Memorial		12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE) Self-employed		12b. KIND OF BUSINESS OR INDUSTRY Taxi Cab	
13a. STATE D.C.		13b. COUNTY Washington		13c. CITY OR TOWN Washington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST William Austin		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Atchison		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 242-16-6047	
17. INFORMANT Myrtis Austin		18. ADDRESS 600 Whittier St. N.W.		19. CITY OR TOWN Washington		20. STATE D.C.	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) metastatic Adenocarcinoma of prostate gland. DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) Cardiomyopathy							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 4/25/ 19 85 , to 4/26/ 19 85 , that (I) (we) lost saw the deceased alive on 4/25/ 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE A. Dabela, M.D.		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 04/26/1985	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS 4404 Queensbury Rd., Riverdale, Md. 20737					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE MAY 02, 1985		23c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN		23d. LOCATION CITY OR TOWN COUNTY STATE Bla DENSBURG MD	
24. FUNERAL DIRECTOR NAME Shelly Bell		ADDRESS 1661 Good Hope Rd. Wash., D.C. S.E.		25a. DATE REC'D. BY REGISTRAR MAY 13 1985		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON - BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed with the funeral director. Page 5 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Mark L. Avery			2a. DATE OF DEATH MONTH DAY YEAR April 12, 1985		2b. HOUR 6:00 P.M.
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR April 11, 1955		6. AGE (IN YEARS LAST BIRTHDAY) 30	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges County, MD.		
10. CITY OR TOWN OF DEATH Laurel	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greater Laurel Beltsville Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mechanic-Self	12b. KIND OF BUSINESS OR INDUSTRY Employed	
13a. STATE Md.			13b. COUNTY PG	13c. CITY OR TOWN Laurel	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Robert Avery			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Betty Burroughs		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes Vietnam		16b. SOCIAL SECURITY NO. 220 66 7806	17. INFORMANT ADDRESS Diane Avery (Wife) Same as 13E		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: (IMMEDIATE CAUSE (a)) <i>respiratory failure</i> DUE TO, OR AS A CONSEQUENCE OF: (b) <i>myocardial infarction</i> DUE TO, OR AS A CONSEQUENCE OF: (c) <i>pneumonia, cerebral hemorrhage</i>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL ILLNESS OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) this hospital attended the deceased from <i>4/11</i> 19 <i>85</i> to <i>4/12</i> 19 <i>85</i> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If not, state date and hour when body was viewed.)					
22b. SIGNATURE <i>Dr. Lewis Dennis</i>		DEGREE		22c. DATE SIGNED <i>4/12/85</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Lewis Dennis, MD		22e. ADDRESS 831 University Blvd. S.S. Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 4/15/85	23c. NAME OF CEMETERY OR CREMATORY National Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Falls Church, Virginia	
24. FUNERAL DIRECTOR NAME Hines/Rinaldi 11800 New Hamp. Ave. S.S. Md.		25a. DATE REC'D. BY REGISTRAR APR 16 1985		25b. REGISTRAR'S SIGNATURE <i>W. J. Davidson</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 above any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

BP



107058

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST George L. Bach			April 08, 1985			5:05P M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR January 15, 1929		6. AGE (IN YEARS LAST BIRTHDAY) 56 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges County MD.			
10. CITY OR TOWN OF DEATH Laurel		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greater Laurel Beltsville Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Manager		12b. KIND OF BUSINESS OR INDUSTRY C. & P. Telephone Co.	
13a. STATE Maryland		13b. COUNTY Howard		13c. CITY OR TOWN Columbia		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 6705 Seneca Drive 21046	
14. FATHER'S NAME FIRST MIDDLE LAST Neils Bach				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jencina Jensen					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) Korea		17. INFORMANT Virginia Bach		ADDRESS Same as #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <u>METASTATIC CARCINOMA OF THE COLON</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4/7/85 - 4/8/85</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <u>SMALL BOWEL OBSTRUCTION</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) this hospital attended the deceased from <u>4/4/85</u> , 19____, to <u>4/8/85</u> , 19____, that (1) (we) lost saw the deceased alive on <u>4/8/85</u> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Barry Raskin, M.D.</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <u>4/8/85</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BARRY S. RASKIN, M.D.				22e. ADDRESS 14201 LAUREL PK. DRIVE LAUREL, MD. 20707					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/11/85		23c. NAME OF CEMETERY OR CREMATORY Crestlawn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Marriottsville			
24. FUNERAL DIRECTOR Leroy M. & Russell C. Witzke Funeral Homes P.A. 5555 Twin Knolls Road, Columbia, Md. 21045				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE APR 12 1985					

BP

10501

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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108119

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 2 1 7 8

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
Charles Alexander Bailey			April 13, 1985			M		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		
Male	Caucasian	January 23, 1904	81			MONTHS DAYS HOURS MIN.		
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	9. BALTIMORE CITY OR COUNTY OF DEATH	10. CITY OR TOWN OF DEATH						
Washington, DC	Prince George's County, MD	Camp Springs						
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
6513 Allentown Road		Painter		Commercial Painting				
13a. STATE			13b. COUNTY			13c. CITY OR TOWN		
Maryland			Prince George's			Camp Springs		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16. WAS DECEASED EVER IN U.S. ARMED FORCES?		
Charles A. Bailey			Mary Carroll			No		
17. INFORMANT			18. SOCIAL SECURITY NO.			19. ADDRESS		
Helen B. Bailey - Same As #13 A-E			579-05-2676			6513 Allentown Road (20748)		
10. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Respiratory Failure</u>								141
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pulmonary Fibrosis</u>								104 years
DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
			HOUR A.M. MONTH DAY YEAR					
21d. INJURY OCCURRED			21e. PLACE OF INJURY			21f. LOCATION		
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>4/12, 1985</u> to <u>4/12, 1985</u> that (I) (we) last saw the deceased alive on <u>4/12, 1985</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE						DEGREE		22c. DATE SIGNED
<u>R. Nedzbala</u>						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		04/15/85
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS		
R. Nedzbala, M. D.						11701 Livingston Road, Suite 101 Fort Washington, Maryland		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION
Burial			April 16, 1985			Resurrection Cemetery		Clinton, Maryland
24. FUNERAL DIRECTOR NAME						25a. DATE REC'D. BY REGISTRAR		
Lee Funeral Home, Inc.						APR 16 1985		
24b. ADDRESS						25b. REGISTRAR'S SIGNATURE		
Old Alexander Ferry Road, Clinton, Maryland								

MEDICAL CERTIFICATION

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UNITED STATES

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1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGES 1, 2, AND 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1. DECEASED NAME (TYPE OR PRINT) Francisco Suba Bangal, Jr.			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> HOUR <input type="checkbox"/> MIN 4-18 1985		
3. SEX Male	4. RACE PHILIPPINO	5. DATE OF BIRTH MONTH OCT. DAY 14 YEAR 1962	6. AGE (IN YEARS) LAST BIRTHDAY 22 YRS.	7. UNDER 1 YR. MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> HOURS <input type="checkbox"/> MIN <input type="checkbox"/>	7c. DATE PRONOUNCED 4-18 1985
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PHILIPPINES	7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		7. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD
10. CITY OR TOWN OF DEATH CHEVERLY	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince Georges General Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LABORER	12b. KIND OF BUSINESS OR INDUSTRY LANDSCAPING
13a. STATE MARYLAND	13b. COUNTY P.G. CO.	13c. CITY OR TOWN RIVERDALE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 6357 64TH AVE. #C-5 / 20737	
14. FATHER'S NAME FIRST FRANCISCO MIDDLE S. LAST BANGAL			15. MOTHER'S MAIDEN NAME FIRST CONSOLACION MIDDLE SUBA LAST SUBA		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 221-58-3011		17. INFORMANT ADDRESS FRANCISCO S. BANGAL (FATHER) SAME AS #13.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR 4 AM 18 MONTH 4 YEAR 1985 P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Hanged self	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home		21f. LOCATION STREET 6357 64th Avenue CITY OR TOWN Riverdale COUNTY Prince Georges STATE Md	
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion					
ACTUAL SIGNATURE Augusto P. Rodriguez		TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER		DATE SIGNED 4-18-85	
EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez, M.D.		ADDRESS 5009 Rayburn Ct., Temple Hills, Md			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE APRIL 24, 1985	23c. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery		23d. LOCATION CITY OR TOWN DOVER COUNTY KENT CO. STATE DELAWARE
24. FUNERAL DIRECTOR NAME CHAMBERS FUNERAL HOME ADDRESS RIVERDALE, M.D.			25a. DATE REC'D. BY REGISTRAR APR 24 1985 25b. REGISTRAR'S SIGNATURE John F. ...		

1882

Handwritten notes and a small sketch of a landscape or map.



Extensive handwritten notes and a larger sketch of a landscape or map, continuing from the top section.

106068

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1 2 1 7 8

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Harold A. Barclay			2a. DATE KNOWN OF DEATH ESTIMATED April 6 1985 MONTH DAY YEAR 2b. HOUR 6:32 PM		
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 5-5-45	6. AGE (IN YEARS) LAST BIRTHDAY 39 YRS.	7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	7c. DATE PRONOUNCED DEAD April 6 1985 MONTH DAY YEAR 2d. HOUR 6:32 PM
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD.	
10. CITY OR TOWN OF DEATH Riverdale		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NONE, GIVE STREET ADDRESS) Leland Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sheet Metal Worker 12b. KIND OF BUSINESS OR INDUSTRY Government	
13a. STATE Maryland		13b. CITY OR TOWN P.G. Maryland		13c. STREET ADDRESS 590i 31st Place 20782	
14. FATHER'S NAME FIRST MIDDLE LAST Harold D. Barclay		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Mullen		17. INFORMANT Margaret T. Barclay Laurel, Md. 20707	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) Vietnam 577-62-2800		17. INFO ^a MANT 8424 Shears Court	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot Wound of Chest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost: (b) DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: None					
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 4 6 1985		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Shot self	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 3106 PL Hyattsville Prince George's MD	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE John S. Rogers, M.D.		TITLE (SPECIFY) M.D. Dep ^y		DATE April 6 1985	
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, M.D.		ADDRESS 1919 Seminary Rd. Silver Spring, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/10/85		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery	
24. FUNERAL DIRECTOR Francis Gasch's Sons Funeral Home P.A. 4739 Baltimore Avenue Hyattsville, Md. 20781		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood P.G. Maryland		25a. DATE REC'D. BY REGISTRAR APR 11 1985	
				25b. REGISTRAR'S SIGNATURE	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT, PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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DHMH - 17
(VR A15 ME (5))

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME FIRST MIDDLE LAST
GLADYS E. BARTON

2a. DATE OF DEATH MONTH DAY YEAR
April 2 1985

2b. HOUR
16:00PM

3. SEX
Female

4. RACE
White

5. DATE OF BIRTH MONTH DAY YEAR
Sept. 21 1893

6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR IF UNDER 24 HRS
91 MONTHS DAYS HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Iowa

7b. CITIZEN OF WHAT COUNTRY?
U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐
WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH
Prince George MD.

10. CITY OR TOWN OF DEATH
Morningside

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
6606 Suitland Rd.

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Nurse

12b. KIND OF BUSINESS OR INDUSTRY
Private Hosp.

13a. STATE
Maryland

13b. COUNTY
Prince Geo.

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE
6606 Suitland Rd. 20746

14. FATHER'S NAME FIRST MIDDLE LAST
John -- McDowell

15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Cora -- Smith

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No

16b. SOCIAL SECURITY NO.
480 07 4328

17. INFORMANT ADDRESS
Daughter Beth B. McAteer Same as #13

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Aspiration pneumonia
(b) Congestion in the chest
(c) Malnutrition with Anorexia
DUE TO, OR AS A CONSEQUENCE OF
DUE TO, OR AS A CONSEQUENCE OF
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a
Old age.

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES ☐ NO ☒
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE ☐ AT WORK NOT WHILE ☐ AT WORK
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 2/27, 1985, to 4/2, 1985, that (I) (we) last saw the deceased alive on April 2, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE B. Hahler Adam, MD DEGREE ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐
22c. DATE SIGNED Apr. 3, 1985

22d. PHYSICIAN'S NAME (TYPE OR PRINT) HAKKI B. ADAM M.D. 22e. ADDRESS 6172 Oxen Hill Rd. / Oxen Hill Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL 23b. DATE Apr. 6, 1985 23c. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial Park 23d. LOCATION CITY OR TOWN COUNTY STATE San Fernando Calif.

24. FUNERAL DIRECTOR DeVol Funeral Home 2222 Wisc Ave. Washington D.C. 25. DATE REC'D. BY REGISTRAR APR 9 1985 26. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

349501

113126

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Charity M. BATES			2a. DATE OF DEATH MONTH DAY YEAR April 12, 1985		2b. HOUR 4:12 P M			
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH JUNE 16, 1913		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS. MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN) NORTH CAROLINA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES COUNTY MD.		
10. CITY OR TOWN OF DEATH LANHAM		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION DOCTORS HOSPITAL			12a. USUAL OCCUPATION (TYPE OF BUSINESS, INDUSTRY OR WORKING LIFE) HOMEMAKER		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) MARYLAND ANNE ARUNDEL PASADENA				13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13c. STREET ADDRESS, ZIP CODE 1825 PARKSIDE DR. 21122		
14. FATHER'S NAME WILLIAM J. HILL			15. MOTHER'S MAIDEN NAME DAISY HILL					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 218 38 7634		17. INFORMANT WILEY E. BATES SON SAME AS 13E				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiac arrest DUE TO, OR AS A CONSEQUENCE OF (b) colony or drug disorder DUE TO, OR AS A CONSEQUENCE OF (c) colony or renal failure PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NO/WHILE <input type="checkbox"/> AT HOME <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) this hospital attended the deceased from 3/20 , 19 85 , to 4/12 , 19 85 , that I (we) lost saw the deceased alive on 4/12 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did) not view the body after death.								
22b. SIGNATURE Lewis H. Dennis M.D.				DEGREE MD		22c. DATE SIGNED 4/12/85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Lewis H. Dennis M. D.				22e. ADDRESS 831 University Blvd. E., Silver Spring Md.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 4-16-85		23c. NAME OF CEMETERY OR CREMATORY LAKEMONT		23d. LOCATION (CITY OR TOWN) COUNTY STATE DAVIDSONVILLE A.A.CO. MD.		
24. FUNERAL DIRECTOR NAME ADDRESS ROBERT E. EVANS ANNAPOLIS, MD. 21401				25a. DATE REC'D. BY REGISTRAR APR 17 1985		25b. REGISTRAR'S SIGNATURE Julia Davidson-Gendall		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the funeral director within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

113452



NO. 113452

SIBU - NOTION 18000

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109100

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW-100. GIVE PAGES 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100 TO FUNERAL DIRECTOR; PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP

DHMH - 17
(VR A15 ME (5))1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
Dorothy W. Baughan								4-3		19		85					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 24 YRS.		8. IF UNDER 24 HRS.		9. DATE PRONOUNCED DEAD		MONTH		DAY	
Female		White		8 1 1925		59 YRS.						4-3		19		85	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		WIDOWED		DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH					
Penna.		USA										XX Prince Georges Co.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		13. KIND OF BUSINESS OR INDUSTRY											
Cheverly		Prince Georges General Hospital		Prof. Secretary		US Governe											
14. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS							
Maryland		PG		Suitland		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				4675 Homer Ave						20746	
14. FATHER'S NAME		FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME		FIRST		MIDDLE		LAST			
Edward						Wendel		Elizabeth						Sloan			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
NO		228-42-4945		David S Carter		20 Beverly Dr										Mechanicville MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
				A sudden pulmonary embolism													
				(b)		DUE TO, OR AS A CONSEQUENCE OF											
				(c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
		HOUR A.M. MONTH DAY YEAR															
		P.M. 19															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION		CITY OR TOWN		COUNTY		STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from:		Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED													
Augusto P. Rodriguez, M.D.		Deputy		4-4-85													
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS															
		5009 Rayburn Ct., Temple Hills, Md															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		COUNTY		STATE							
Burial		4/6/85		Resurrection Cemetery		Clinton		PG		MD							
24. FUNERAL DIRECTOR NAME		24. FUNERAL HOME		24. FUNERAL HOME		24. FUNERAL HOME		24. FUNERAL HOME		24. FUNERAL HOME		24. FUNERAL HOME		24. FUNERAL HOME		24. FUNERAL HOME	
Robert E. Wilhelm		Funeral Home		Suitland Rd		Suitland MD											

APR 15 1985

J. Davidson

100100



20% COTTON LINES

WATSON

Copy

10-10-10

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Edith S. Becraft			7a. DATE OF DEATH MONTH DAY YEAR April 27, 1985		7b. HOUR 5:45A.
3. SEX FEMALE	4. RACE CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR 3 27 1911		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) LAUREL	7b. CITIZEN OF WHAT COUNTRY? US	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD	
10. CITY OR TOWN OF DEATH LAUREL	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greater Laurel Beltsville Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE MD			13b. COUNTY PG	13c. CITY OR TOWN LAUREL	
14. FATHER'S NAME FIRST MIDDLE LAST GEORGE TILGHMAN SELLERS			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BERTHA MIRIAM SEIBEL		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 217-12-2779		17. INFORMANT ADDRESS HARRY EDWARD BECRAFT 13E	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (b) Coronary insufficiency DUE TO, OR AS A CONSEQUENCE OF (c) Surgical stress PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: NO					
19a. DATE OF OPERATION 4.24.84.		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Breast Cancer		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (Enter nature of injury in item 18 Part 1 or Part 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 4.24.85 , 19____, to 4.27.85 , 19____, that (I) (we) last saw the deceased alive on 4.26.85 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Habib A. Bhutta		DEGREE M.D.		22c. DATE SIGNED 4/27/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HABIB A BHUTTA		22e. ADDRESS 14201 Laurel Park Drive Laurel Md. 20707			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 4/30/85		23c. NAME OF CEMETERY OR CREMATORY UNION CEMETERY	
23d. LOCATION CITY OR TOWN COUNTY STATE BELTSVILLE MONT. MD.		24. FUNERAL DIRECTOR NAME ADDRESS FLECK FUNERAL HOME INC. LAUREL, MD. 20707			
25. DATE REC'D. BY REGISTRAR MAY 1 1985		25b. REGISTRAR'S SIGNATURE [Signature]			

BP _____

DHMH - 16 50M 4/83
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

126082

A

Reland Nebel Homing Case



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME
(TYPE OR PRINT)

FIRST MIDDLE LAST
Louise **JEANNETTE** *Bell*

2a. DATE KNOWN OF DEATH
ESTIMATED ☒ MONTH DAY YEAR
4-23 19*85*

3. SEX
Female

4. RACE
White

5. DATE OF BIRTH
MONTH DAY YEAR
April 8, 1933

6. AGE (IN YEARS)
(LAST BIRTHDAY)
52 YRS.

IF UNDER 1 YR.
MONTHS DAYS

IF UNDER 24 HRS.
HOURS MIN

7c. DATE PRONOUNCED DEAD
MONTH DAY YEAR
4-23 19*85*

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland

7b. CITIZEN OF WHAT COUNTRY?
U.S.A.

8. MARRIED ☒ NEVER MARRIED ☐
WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH
Prince George's MD

10. CITY OR TOWN OF DEATH
Cheverly

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Prince Georges General Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife

12b. KIND OF BUSINESS OR INDUSTRY
Own Home

13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE
Md.

13b. COUNTY
Pr. Geo's

13c. CITY OR TOWN
Upper Marlboro

13d. INSIDE CITY LIMITS?
YES ☒ NO ☐

13e. STREET ADDRESS
14731 Crescent Drive/20772

14. FATHER'S NAME
FIRST MIDDLE LAST

Robert

Nelson

Windsor

15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST

Martha

Ellen

Thomas

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
No

16b. SOCIAL SECURITY NO.
--

17. INFORMANT
ADDRESS
*14731 Crescent Drive,
William T. Bell-Upper Marlboro, Md. 20772*

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE OF DEATH

Diabetic enteric ulcer with candida superinfection

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last

(b) DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE ☐ NOT WHILE ☐ AT WORK ☐ AT WORK

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION
STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE
Augusto P. Rodriguez

DATE (SPECIFY)
4-24-85

MEDICAL EXAMINER

DATE SIGNED
4-24-85

EXAMINER'S NAME (TYPE OR PRINT)
Augusto P. Rodriguez, MD

ADDRESS
5009 Rayburn Ct., Camp Springs, Md. 20746

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial

23b. DATE
4/27/85

23c. NAME OF CEMETERY OR CREMATORY
Resurrection Cemetery

23d. LOCATION
CITY OR TOWN COUNTY STATE
Clinton (Pr. Geo.) Md.

24. FUNERAL DIRECTOR

Richard A. Coleman -Upper Marlboro, Md. 20772
Funeral Home

25a. DATE REC'D. BY REGISTRAR
APR 26 1985
REGISTRAR'S SIGNATURE
John Davidson-Henderson

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAYS ARE NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE KEPT, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84
25M

BP

DHMH - 17
(VR A15 ME (5))



1060788

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP
DHMH - 17
(VR A15 ME (5))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

85-12184

REG. NO.

1- STATE REGISTRAR										2a. DATE KNOWN OF DEATH										2b. HOUR									
1. DECEASED NAME (TYPE OR PRINT)										2c. DATE ESTIMATED										2d. HOUR									
Abraham Albert Berk										4/2 19 85										A. 11:07									
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS)			IF UNDER 1 YR.			IF UNDER 24 HRS.			7c. DATE PRONOUNCED DEAD			7d. HOUR								
Male			White			Aug. 1, 1907			77 YRS.									4/4 19 85			A. 11:07								
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)					7b. CITIZEN OF WHAT COUNTRY?					8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					9. BALTIMORE CITY OR COUNTY OF DEATH														
New York City					U.S.A.										Prince George's County MD														
10. CITY OR TOWN OF DEATH					11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)					12b. KIND OF BUSINESS OR INDUSTRY									
Hyattsville					4113 Kennedy Street										Chemical Engineer					Bureau of Mines									
13a. STATE					13b. COUNTY					13c. CITY OR TOWN					13d. INSIDE CITY LIMITS?					13e. STREET ADDRESS									
Maryland					Prince George's					Hyattsville					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					4113 Kennedy Street 20781									
14. FATHER'S NAME										15. MOTHER'S MAIDEN NAME										16. SOCIAL SECURITY NO.									
Harry Berk										Esther Unknown										220-34-4335									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)										16b. SOCIAL SECURITY NO.										17. INFORMANT									
No										220-34-4335										Mr. Kenneth Berk									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
PART I DEATH WAS CAUSED BY:																													
IMMEDIATE CAUSE (a) <u>Gastrointestinal hemorrhage.</u>																													
DUE TO, OR AS A CONSEQUENCE OF																													
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.																													
(b) _____																													
DUE TO, OR AS A CONSEQUENCE OF																													
(c) _____																													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1																													
None																													
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY?														
None															YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH					21b. TIME OF INJURY					21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																			
					P.M. 19					None																			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)					21f. LOCATION																			
										STREET CITY OR TOWN COUNTY STATE																			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																													
ACTUAL SIGNATURE										TITLE (SPECIFY)										DATE SIGNED									
John S. Rogers, M.D.										Deputy										5/9/85									
EXAMINER'S NAME (TYPE OR PRINT)										ADDRESS																			
John S. Rogers, M.D.										1919 Seminary Road										Silver Spring, Montgomery, Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION														
Cremation					April 7, 1985					Metropolitan Crematory					Alexandria N/A Virginia														
24. FUNERAL DIRECTOR										25a. DATE REC'D. BY REGISTRAR										25b. REGISTRAR'S SIGNATURE									
F. Gasch's Sons F.H. P.A.										MAY 16 1985										John S. Rogers									

BP _____
DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrars, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2, should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH				
FIRST MIDDLE LAST Birdie F. Bertram					MONTH DAY YEAR April 11, 1985				
3 SEX		4 RACE		5. DATE OF BIRTH		6. AGE (IN YEARS (LAST BIRTHDAY))		2b. HOUR	
FEMALE		CAUC		MONTH DAY YEAR 10-25-1898		86 YRS.		1:50P M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
VIRGINIA		USA				PRINCE GEORGES MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)							
FT. WASHINGTON		Ft. Washington Rehabilitation Center							
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
HOUSEWIFE									
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13d. STREET ADDRESS / ZIP CODE			
MD		P.G.		COLLEGE PARK YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3617 IROQUES ST 20740			
14. FATHER'S NAME FIRST MIDDLE LAST THOMAS D. FICKLIN, TN					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FANNY				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)					16b. SOCIAL SECURITY NO.		17. INFORMANT		
NO					57752-6341		Mrs. Alice Weaver, 8603 Adios St, Clinton, Md 20735		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Pneumonia</u>									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
(b) _____									
DUE TO, OR AS A CONSEQUENCE OF									
(c) _____									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) this hospital attended the deceased from <u>5-3</u> 19 <u>84</u> , to <u>4-11</u> 19 <u>85</u> , that (I) was last saw the deceased alive on <u>4-11</u> 19 <u>85</u> , and that in (my) our opinion death occurred on the date and hour and from the causes stated above, (I) was (did not) view the body after death.									
22b. SIGNATURE					DEGREE			22c. DATE SIGNED	
<u>William Kent Furst</u>					MD			04/11/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS				
William K. Furst, M. D.					11701 Livingston Road, #101 Ft. Washington, Maryland				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
BURIAL		April 12, 85		Cedar Hill Cemetery,		Suitland, P.G., Maryland			
24. FUNERAL DIRECTOR NAME ADDRESS					25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE				
LEE FUNERAL HOME, 6633 Old Alexander Ferry Road, Clinton, Maryland 20735					APR 16 1985				

20% COTTON FIBRE

MADE IN INDIA



151201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

116104

DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR
ROSIE A BIGGS					4	16	85		11:14 PM
3 SEX	4 RACE	5. DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		
Female	Caucasian	Oct. 3 1903		81	MONTHS		DAYS		
7a BIRTHPLACE (COUNTRY)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH					
Maryland	U.S.A.			PRINCE GEORGES					
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY				
Clinton	Southern Md. Hospital		Meat Packer		Briggs Meat				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d INSIDE CITY LIMITS?		13e STREET ADDRESS / ZIP CODE			
13a STATE				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20748			
13b COUNTY									
13c CITY OR TOWN									
Maryland Prince Georges Camp Springs									
FATHER'S NAME				15 MOTHER'S MAIDEN NAME					
John Lee Biggs				Elizabeth Louise Schroth					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b SOCIAL SECURITY NO		17 INFORMANT			
No				578-03-8022 A		Louise Miller			
						3511 - 27th Ave. Hillcrest Heights, Md.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									18b INTERVAL BETWEEN ONSET OF ILLNESS AND DEATH <u>15 days</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. (a) <u>Acute Subdural Hematoma - Multiple CVA's.</u>									
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
3/24/85		Acute Subdural Hematoma			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22 I certify that (I) (this hospital) attended the deceased from <u>3/20</u> 19 <u>85</u> to <u>4/16</u> 19 <u>85</u> , that (I) (y) last saw the deceased alive on <u>4/16</u> 19 <u>85</u> , and that in (my) (a) opinion death occurred on the date and hour and from the causes stated above. (I) (a) (did not) view the body after death.									
22a SIGNATURE				DEGREE			22c. DATE SIGNED		
Joseph P. Caruso M.D.				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			4/17/85		
22d PHYSICIAN'S NAME (TYPE OR PRINT)				22e ADDRESS					
Joseph P. Caruso, M.D.				9131 P's CATHOLIC AND CLINICAL MD.					
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d LOCATION			
Burial		4/19/85		Cedar Hill Cemetery		Sutland P.G. Maryland			
24 FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
George P. Kelas 6160 OXON HILL RD.				APR 19 1985		Julia Davidson-Randall			

10. HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, please detach for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

7



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, FILE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 10A.3. RETAIN PAGE 5 FOR YOUR FILE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP

DHMH - 17
(VR A15 ME (5))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)				2a. DATE KNOWN OF DEATH				2b. DATE OF DEATH				2c. DATE PRONOUNCED DEAD			
FIRST MIDDLE LAST Nevin Carroll Bollinger				MONTH DAY YEAR April 1 1988				MONTH DAY YEAR April 1 1988				HOUR MIN 5:27 PM			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		7. IF UNDER 1 YR.		8. IF UNDER 24 HRS.		9. BALTIMORE CITY OR COUNTY OF DEATH			
Male		White		MONTH DAY YEAR 12 26 1918		LAST BIRTHDAY YRS. 66		MONTHS DAYS HOURS MIN YRS.				Prince George's County MD.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH			
Maryland				U.S.A.								Prince George's County MD.			
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
College Park				5209 Edgewood Road				Animal Husbandry				Dept. of Agriculture			
13a. STATE				13b. CITY OR TOWN				13c. STREET ADDRESS				13d. INSIDE CITY LIMITS?			
Maryland				P.G.				College Park				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME				16a. WAS DECEASED EVER IN U.S. ARMED FORCES?				16b. SOCIAL SECURITY NO.			
FIRST MIDDLE LAST Ray H. Bollinger				FIRST MIDDLE LAST Lenora Munson				YES <input type="checkbox"/> NO <input type="checkbox"/> (YES, GIVE WAR OR DATES) W.W.II				214-28-8950			
17. INFORMANT				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)				19. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			
Erika E. Bollinger (Wife) Same as 13e				PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chr. Bronchitis & Emphysema</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>None</u> PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>None</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?							
None								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				TITLE (SPECIFY) M.D. <u>John S. Rogers</u> MEDICAL EXAMINER				DATE SIGNED April 1 1988							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial				4/5/85				Fort Lincoln Cemetery				Brentwood P.G. Maryland			
24. FUNERAL DIRECTOR'S NAME				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE							
Francis Casch's Sons Funeral Home, P.A. 4739 Baltimore Ave. Hyattsville, Md. 20781				APR 4 1985				John Davidson-Rodgers							

1000

FOR COPIES

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BP

DHMH - 16 60M 7/84
(VRA 15, 4) 6633

108118

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) EUGENIA C BONE			2a. DATE OF DEATH MONTH DAY YEAR APRIL 12 1985			2b. HOUR 10⁰⁷ AM			
3 SEX Female		4 RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR January 1, 1895		6 AGE (IN YEARS LAST BIRTHDAY) 90 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Indiana		7b CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE MD.			
10 CITY OR TOWN OF DEATH Clinton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Maryland Hospital				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher		12b KIND OF BUSINESS OR INDUSTRY Public School	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Prince George's		13c. CITY OR TOWN Ft. Washington		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e STREET ADDRESS / ZIP CODE System 1407 Taylor Street (20744)	
14 FATHER'S NAME FIRST MIDDLE LAST Culbertson				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17 INFORMANT 11007 Phillips Drive Eileen Watkins Upper Marlboro, Maryland 20772					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL VASCULAR ACCIDENT								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) _____									
DUE TO, OR AS A CONSEQUENCE OF (c) _____									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. ARTERIO SCLEROTIC HEART DISEASE, ATRIAL FIBRILLATION, CONGESTIVE HEART FAILURE, BRONCHITIS, URINARY TRACT INFECTION									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from MARCH 28 19 85 to APRIL 12 19 85 , that (I) (we) last saw the deceased alive on APRIL 12 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Helen Capone				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED APRIL 12/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Helen CAPONE				22e. ADDRESS 7501 SURRATTS RD CLINTON MD 20735					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE April 15, 1985		23c. NAME OF CEMETERY OR CREMATORY Lee's Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Clinton, Maryland			
24 FUNERAL DIRECTOR NAME Lee Funeral Home, Inc.				25a. DATE RECD. BY REG. NO. APR 16 1985		25b. REG. NO. 12188			
25c. ADDRESS Old Alexander Ferry Road, Clinton, Maryland									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR				2a. DATE OF DEATH				2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOSEPH P. BOQUEL				MONTH DAY YEAR 04 04 85				12 40PM			
3. SEX Male		4. RACE White		5. DATE OF BIRTH Sept. 18, 1912		6. AGE (IN YEARS LAST BIRTHDAY) 72		7. UNDER 1 YEAR MONTHS DAYS		8. UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES COUNTY MD.					
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGES GENERAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Broker		12b. KIND OF BUSINESS OR INDUSTRY Real Estate			
13a. STATE Maryland				13b. COUNTY Prince Georges Greenbelt		13c. CITY OR TOWN YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		11. STREET ADDRESS / ZIP CODE 11 M Laurel Hill Road 20770			
14. FATHER'S NAME FIRST MIDDLE LAST Peter Joseph Boquel				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Anne Ahearn							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				16b. SOCIAL SECURITY NO. 171-09-4207		17. INFORMANT ADDRESS Joseph T. Boquel same as 13e					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) _____											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Chronic obstructive disease</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>dehydration, weight loss</u>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 19 <u>85</u> to <u>APRIL 4</u> 19 <u>85</u> that (I) (we) last saw the deceased alive on <u>APRIL 3</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.											
22b. SIGNATURE <u>Don B. Cameron MD</u>								DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4-4-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DON B. CAMERON MD								22e. ADDRESS 6005 LANDOVER RD CHEVERLY MD 20785			
23a. BURIAL, CREMATION, REMOVAL (SPEC) Burial				23b. DATE 4/9/85		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring, Maryland	
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home, Inc. 1331 Rockville Pike, Rockville, Maryland 20852								25a. DATE REC'D. BY REGISTRAR APR 12 1985 25b. REGISTRAR'S SIGNATURE HKN 12 1985			

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-10. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Cora Lee Boyd			2a. DATE KNOWN OF DEATH MONTH DAY YEAR ESTI. MATED 4-8-85			2b. HOUR M 12 P 12		
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 10-23-01	6. AGE (IN YEARS) (LAST BIRTHDAY) YRS. 83	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR APRIL 8 1985		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington DC		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD		
10. CITY OR TOWN OF DEATH Temple Hills		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5416 Fisher Drive				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HomeMaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home
13a. STATE Maryland		13b. COUNTY Pr George		13c. CITY OR TOWN Temple Hills		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST James W. Steele		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Glascoe		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				
16b. SOCIAL SECURITY NO. 578-09-3545		17. INFORMANT ADDRESS Clarence R. Boyd Same as #13						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ischemic heart disease DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE Augusto P. Rodriguez		TITLE (SPECIFY) Deputy			DATE SIGNED 3-8-85			
EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez, M.D.		ADDRESS 5009 Rayburn Ct., Temple Hills, Md						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10 April 1985		23c. NAME OF CEMETERY OR CREMATORY Washington National		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland PG Md		
24. FUNERAL DIRECTOR NAME Robert E Wilhelm		ADDRESS Funeral Home		25. DATE REC'D. BY REGISTRAR APR 15 1985		26. REGISTRAR'S SIGNATURE John Davidson-Randall		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST				2b. HOUR			
Clyde West Boydston				April 15, 1985 4:15 AM			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)	
MALE		BLACK		9 28 1900		84 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Kansas		USA				PG MD	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Seat Pleasant		4307 North Addison Road		Retired			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Maryland		PG		Seat Pleasant		NO	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		13e. STREET ADDRESS			
Jacob Boydston		Mattie (unknown)		20743 4307 North Addison Road			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
no		577 10 8559		Lenora Boydston-daughter-4630 Colfax Circle, Lincoln, Neb			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Adeno Carcinoma Stomach</u>							
DUE TO, OR AS A CONSEQUENCE OF (b) _____							
DUE TO, OR AS A CONSEQUENCE OF (c) _____							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this hospital) attended the deceased from <u>3/25</u> 19 <u>85</u> to <u>4/12/85</u> 19 <u>85</u> , that (I) (was) lost saw the deceased alive on <u>2/23/85</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death							
22a. SIGNATURE <u>Eugene C. Vanston</u>				DEGREE <u>M.D.</u>		22c. DATE SIGNED <u>4/15/85</u>	
22b. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Eugene C. Vanston M.D.</u>				22d. ADDRESS <u>WASH. 37-D.C. 4650 Livingston Rd SE</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		Apr. 15, 1985		Maryland National		Laurel, Maryland	
24. FUNERAL DIRECTOR NAME <u>John T. Stewart III</u>				25. DATE REC'D. BY REGISTRAR <u>APR 23 1985</u>			
Stewart Funeral Home-4001 Benning Road, NE.				25b. REGISTRAR'S SIGNATURE <u>Davidson-Rendell</u>			

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Charles A. Brady			2a. DATE OF DEATH MONTH DAY YEAR 4/30/85		2b. HOUR 12 ³⁰ M
3. SEX male	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR Sept 11, 1899		6. AGE (IN YEARS LAST BIRTHDAY) 85	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD.	
10. CITY OR TOWN OF DEATH Greenbelt	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greenbelt Convalescent Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) machinist	12b. KIND OF BUSINESS OR INDUSTRY U S Govt	
13a. STATE Md	13b. COUNTY P. G.	13c. CITY OR TOWN Beltsville	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 11419 Cedar Lane 20705	
14. FATHER'S NAME FIRST MIDDLE LAST Albert Cook Brady		15. MOTHER'S MAIDEN NAME MIDDLE LAST Margaret Gates			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 215 44 7418		17. INFORMANT ADDRESS Charles A. Brady, Jr 12525 Old Gunpowder Rd Beltsville, Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>chronic obstructive Pulmonary Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerosis</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 18					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) this hospital attended the deceased from <u>4-19</u> 19 <u>85</u> , to <u>4-30</u> 19 <u>85</u> , that (2) we lost saw the deceased alive on <u>4-19</u> 19 <u>85</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death.)					
22b. SIGNATURE David S. Schachter		DEGREE DO		22c. DATE SIGNED 4/30/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) David S. Schachter		22e. ADDRESS 115 Gutting / Greenbelt, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE May 3, 1985		23c. NAME OF CEMETERY OR CREMATORY George Washington Cem	
23d. LOCATION Adelphi, Md		COUNTY		STATE	
24. FUNERAL DIRECTOR NAME Donaldson Funeral Home, Laurel, Md			25a. DATE REC'D. BY REGISTRAR MAY 09 1985		
ADDRESS			25b. REGISTRAR'S SIGNATURE John F. ...		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified and a separate report will be required.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR P) FIRST MIDDLE LAST MARGARET ANNE BRITTEN			2a. DATE OF DEATH MONTH DAY YEAR 4/28/85		2b. HOUR 11 35 A.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 08 26 1925		
6. AGE (IN YEARS, LAST BIRTHDAY) 59 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		8. IF UNDER 24 HRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
10. CITY OR TOWN OF DEATH Riverdale		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NONE IN CITY OR TOWN, GIVE STREET ADDRESS) Leland Memorial Hospital		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD.		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Payroll Clerk		12b. KIND OF BUSINESS OR INDUSTRY U.S. Government				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						
13a. STATE Maryland		13b. COUNTY P.G.		13c. CITY OR TOWN Hyattsville		
14. FATHER'S NAME FIRST MIDDLE LAST James English		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Broderick		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 204-12-9697		17. INFORMANT ADDRESS 7707 13th St. N.W. Judith Anne Wimmel (Daughter) Washington, D.C.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma of the lung, stage III</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) _____						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>Feb 21</u> 19 <u>85</u> to <u>April</u> 19 <u>85</u> that (I) (we) last saw the deceased alive on <u>4-28</u> 19 <u>85</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <u>Kai-Yin Yeung, MD</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4-29-85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Kai-Yin Yeung, MD</u>		22e. ADDRESS <u>8926 Woodyard Rd #201 Clinton, Md 20735</u>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 4/29/85		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory		
23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria N/A Virginia		23e. DATE REC'D. BY REGISTRAR MAY 8 1985				
23f. REGISTRAR'S SIGNATURE <u>Juan Davidson-Randall</u>						

MEDICAL CERTIFICATION

29

1

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



2/10/72

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) MARY GRAHAME BROOKE			2a. DATE OF DEATH MONTH DAY YEAR 4-3-85			2b. HOUR 1130 P^M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 12 / 24 / 1889		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD.	
10. CITY OR TOWN OF DEATH Laurel		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 416 Compton Ave. (Home)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. STATE Md.		13b. COUNTY P.G.		13c. CITY OR TOWN Laurel		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Malcolm ---- Grahame		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary ---- Ireland		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 219-10-1933A	
17. INFORMANT ADDRESS Mary Anna B. Rice 409 Prince George St., Laurel Md. 20707							

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

RESPIRATORY FAILURE

DUE TO, OR AS A CONSEQUENCE OF

ASPIRATION PNEUMONIA

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

GASTRITIS

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
------------------------	--	--	--

21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the decedent from **APPROX 3/15** 19 **85**, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) we (did not) view the body after death.

22b. SIGNATURE [Signature]	DEGREE MD	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 4/4/85
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22d. PHYSICIAN'S NAME (TYPE OR PRINT) GREGORY A COMPTON MD	22e. ADDRESS 4201 LAUREL PARK DR #221 LAUREL MD 20707
--	---

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 4/8/85	23c. NAME OF CEMETERY OR CREMATORY Trinity Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Upper Marlboro, (Pr. Geo's) Md.
24. FUNERAL DIRECTOR Richard A. Coleman - Upper Marlboro, Md. 20772 Funeral Home		25a. DATE REC'D. BY REGISTRAR APR 17 1985	25b. REGISTRAR'S SIGNATURE [Signature]



105062

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

DMMH - 16 60M 7/84
(VRA 15, 4)1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Kathleen Marie BROOKS			2a. DATE OF DEATH MONTH DAY YEAR March 29, 1985		2b. HOUR 5:55 A.M.				
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 7 20 1951		6. AGE (IN YEARS LAST BIRTHDAY) 33 YES <input type="checkbox"/> NO <input type="checkbox"/>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.			
10. CITY OR TOWN OF DEATH Lanham		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Doctors' Hospital of Pr. Geo. Co.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Maid		12b. KIND OF BUSINESS OR INDUSTRY P.G. County Bd of Ed.		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD		13b. COUNTY P.G.		13c. CITY OR TOWN Landover		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 6319 Landover Rd #303 20785	
14. FATHER'S NAME FIRST MIDDLE LAST Dennis Smith			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marie Pender						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-56-6808		17. INFORMANT ADDRESS Ernest J. Brooks 6319 Landover Rd #303 Landover, MD 20785					
18. CAUSE OF DEATH (Enter only one cause per line by (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiac failure DUE TO, OR AS A CONSEQUENCE OF (b) pericardial effusion DUE TO, OR AS A CONSEQUENCE OF (c) metastatic carcinoma PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (b): malnutrition, alcohol abuse								APPROPRIATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 3:24 3/29 1985		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 831 Univ. Blvd E., Silver Spring, Md. 20903					
22a. I certify that (1) this hospital attended the deceased from 3/29 1985 to 3/29 1985 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If two (add) did not view the body after death.									
22b. SIGNATURE Lewis H. Dennis		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/29/85			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) LEWIS H. DENNIS, M.D.				22e. ADDRESS 831 Univ. Blvd E., Silver Spring, Md. 20903					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/2/85		23c. NAME OF CEMETERY OR CREMATORY Harmony Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Lanover Prince George's MD			
24. FUNERAL DIRECTOR NAME ROLLINS FUNERAL HOME, INC.				24a. DATE REC'D. BY REGISTRAR APR 08 1985				24b. REGISTRAR'S SIGNATURE Johanna Davidson-Pender	
24c. ADDRESS 4339 HUNT PLACE, N.E. WASHINGTON, D.C. 20019									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

BP

105063



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ROLLINS FUNERAL HOME, INC.
4333 HUNT PLACE, N.E.
WASHINGTON, D.C. 20019

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 must be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) WILLIAM E. BROOKS, Jr.		2a. DATE OF DEATH MONTH DAY YEAR 4 26 85		2b. HOUR M AM
3. SEX MALE	4. RACE BLACK	5. DATE OF BIRTH MONTH DAY YEAR 3 23 26		6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE COUNTY MD.
10. CITY OR TOWN OF DEATH SEAT PLEASANT	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6714 Hasting Drive		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Court Clerk	
13a. STATE MARYLAND	13b. CITY OR TOWN P.G.	13c. CITY OR TOWN SEAT PLEASANT	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM E. BROOKS, Sr.		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARGARET FIELDS		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. W.W.II 220-16-4951		17. INFORMANT ADDRESS Seat Pleasant, Maryland 20743 PHYLISS BROOKS 6714 Hasting Drive
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Lymphocytic Leukemia DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3yrs
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE
22a. I certify that (I) (this hospital) attended the deceased from above, (I) (we) (did) (did not) view the body after death				
22b. SIGNATURE Richard F. Ambador		DEGREE Attending Physician		22c. DATE SIGNED 4/29/85
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Richard F. Ambador		22e. ADDRESS Johns Hopkins Oncology Ctr		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION	23b. DATE 4-30-85	23c. NAME OF CEMETERY OR CREMATORY GREENMOUNT CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland
24. FUNERAL DIRECTOR WILLIAM REESE & SONS MORTUARY, P.A.		25a. DATE REC'D. BY REGISTRAR APR 29 1985		
25b. REGISTRAR'S SIGNATURE John Davidson-Rendell				

1. The first step is to identify the problem or question that needs to be answered. This involves understanding the context and the specific requirements of the task.

114013

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
CARRIE		13 April 1985		8:50 a.m.	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	
Female	Black	July 4 1905	79	MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Virginia	United States		Prince Georges County MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
Lanham	Doctors' of P G County	None	None		
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. STREET ADDRESS / ZIP CODE		
Maryland	Prince George	Capitol Heights	5314 Cumberland St. 20743		
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME	ADDRESS			
Unknown	Unknown	Capitol Heights, MD.			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS		
No	578-78-5787	Alma SAVAGE	5314 Cumberland St.		
18. CAUSE OF DEATH Enter only one cause per line for each part.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a)					
DUE TO, OR AS A CONSEQUENCE OF					
Septicemia and To					
Multiple Deep Decubital Ulcer					
with Malnutrition & Polydipsia					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
		YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
	HOUR A.M. MONTH DAY YEAR				
	P.M. 19				
21d. INJURY OCCURRED	21e. PLACE OF INJURY	21f. LOCATION			
AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)	STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 3-20-85, 1985, to 4-13-85, 1985, that (I) (we) last saw the deceased alive on 4-13-85, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) move the body after death.	22b. SIGNATURE				
22c. DATE SIGNED					
Benjamin Pecson					4-13-85
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS
Benjamin Pecson					6106 Old Silver Hill Rd. District Heights Md.
23a. BURIAL, CREMATION, REMOVAL	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION		
Burial	4-16-85	Resurrection	Clinton		
24. FUNERAL DIRECTOR	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE			
Comer-Hodges Funeral Home	APR 18 1985	Julia Anderson-Randall			

610811

130018

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OF PRINT) FIRST MIDDLE LAST Lester Heathen BROWN			2a. DATE OF DEATH MONTH DAY YEAR April 16, 1985		2b. HOUR 6:55P M			
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR Oct. 15, 1899		6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS 85		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD		
10. CITY OR TOWN OF DEATH Lanham		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Doctors' Hospital of Pr. Geo. Co.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Truck driver		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland				13b. COUNTY PG		13c. CITY OR TOWN Cedar Heights		
13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO				13e. STREET ADDRESS / ZIP CODE 6308 L Street 20767				

14. FATHER'S NAME FIRST MIDDLE LAST Peter Brown		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST unknown	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218 03 8502	
17. INFORMANT Mary Fletcher--daughter		ADDRESS 5105 Church Road-Mitchellville Md.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

CPD

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
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21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
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21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
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22a. I certify that (I) (this hospital) attended the deceased from **4/11** 19 **85**, to **4/11** 19 **85**, that (I) (we) last saw the deceased alive on **4/11** 19 **85**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE Gerardo M. Gacac		DEGREE MD		22c. DATE SIGNED	
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22d. PHYSICIAN'S NAME (TYPE OR PRINT) GERARDO M GACAD		22e. ADDRESS 6492 LANDOVER RD LANDOVER MD 20785	
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23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE April 20, 1985		23c. NAME OF CEMETERY OR CREMATORY Brown Family Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Chesterfield, Va	
24. FUNERAL DIRECTOR NAME Stewart Funeral Home 4001 Benning Road				25a. DATE REC'D. BY REGISTRAR APR 23 1985		25b. REGISTRAR'S SIGNATURE [Signature]	

RECEIVED
OFFICE OF THE SECRETARY OF THE ARMY
WASHINGTON, D. C.

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ROY L. BROWN			2a. DATE OF DEATH MONTH DAY YEAR 04-06-85		2b. HOUR 7:10PM	
3 SEX Male		4 RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR March 6 1904		
6 AGE (IN YEARS LAST BIRTHDAY) 81 YRS		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		
8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S MD.				
10 CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION PRINCE GEORGE'S GENERAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK OR MOST RECENT WORKING INDUSTRY) Ret. Chauffeur		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE 13c. COUNTY 13d. CITY OR TOWN 13e. INSIDE CITY LIMITS? 13f. STREET ADDRESS / ZIP CODE Md. Pr. Geo. Cottage City YES NO 4142-Bunker Hill Rd. 20722						
14 FATHER'S NAME FIRST MIDDLE LAST Roy Brown			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie (Unknown)			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 579-03-8251		17. INFORMANT ADDRESS Garnet E. Brown - above address (Wife)		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure AR D.S.</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>C.O.P.D., Cardiac arrhythmia, Cerebral artery disease.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cancer colon.</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Post CVA</u>						
19a. DATE OF OPERATION 16 Feb 85. Colon surgery		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Cancer colon and Resp. failure		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR N/A 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) N/A		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> N/A		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) N/A		21f. LOCATION STREET CITY OR TOWN COUNTY STATE N/A		
22a. I certify that (I) (this hospital) attended the deceased from Feb. 3rd, 1985, to SAT 6th, 1985, that (I) (we) lost saw the deceased alive on FRI 5th April 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Raman R. Tuli		DEGREE MD.		22c. DATE SIGNED 4-8-85.		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RAMAN R. TULI MD.		22e. ADDRESS 3601 TAYLOR ST. BRENTWOOD, MD 20722.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/10/1985		23c. NAME OF CEMETERY OR CREMATORY Arlington Nat. Com.		
23d. LOCATION CITY OR TOWN COUNTY STATE Arlington Va.						
24. FUNERAL DIRECTOR NAME Nalley's F.H. Inc.		ADDRESS Mt. Rainier, Md.		25a. DATE REC'D. BY REGISTRAR APR 12 1985		
25b. REGISTRAR'S SIGNATURE John Davidson						

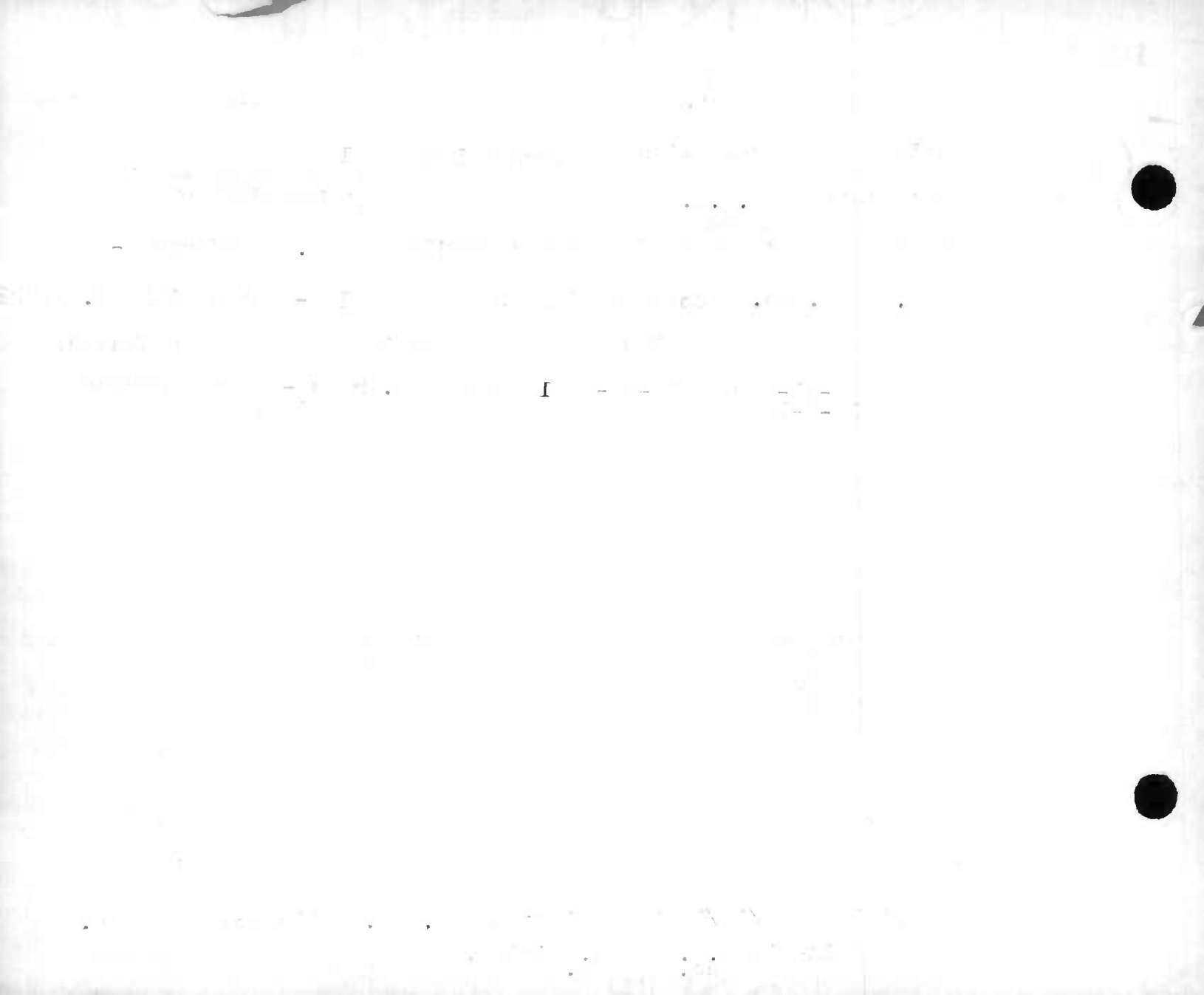
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH 4	DAY 2	YEAR 85	2b. HOUR 1.56pm
1. DECEASED NAME (TYPE OR PRINT)		FIRST LAURA	MIDDLE W	LAST BUNNS			
3. SEX Female	4. RACE Black	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
		1 MONTH 30 DAY 32 YEAR		53 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES COUNTY MD.			
10. CITY OR TOWN OF DEATH CLINTON MD	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTHERN MARYLAND HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Nurse		12b. KIND OF BUSINESS OR INDUSTRY Hospital	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE MD	13b. COUNTY P.G.	13c. CITY OR TOWN Largo	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 11315 Kettering Way 20772			
14. FATHER'S NAME FIRST MIDDLE LAST Wayman Williams		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alberta Bell					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 227-42-9770		17. INFORMANT John D. Bunns		ADDRESS 11315 Kettering Way Largo, Maryland 20772	
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cancer of pancreas with diffuse</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>subcutaneous metastases</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>3/27/</u> 19 <u>85</u> to <u>4/2/</u> 19 <u>85</u> that (I) (we) last saw the deceased alive on <u>4/2/</u> 19 <u>85</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>[Signature]</u>		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/3/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) L. BERWA		M.D.		22e. ADDRESS 9015 WOODYARD RD. CLINTON MD.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/8/85		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION CITY OR TOWN COUNTY STATE Arlington Arlington Virginia	
24. FUNERAL DIRECTOR NAME ROLLINS FUNERAL HOME, INC. 4339 HUNT PLACE, N.E. WASHINGTON, D.C. 20019				25a. DATE REC'D. BY REGISTRAR APR 10 1985			
				25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

MEDICAL CERTIFICATION

BP

TO HOSPITAL, ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as above, show any injury, or other traumatic event, the medical examiner, who is certifying cause of death.

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WASHINGTON, D. C. 20010
4330 HUNT PLACE, N.E.
ROLLING FURNITURE HOME, INC.

109028

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGES 1, 2, AND 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 1 2 2 0 2	
1. DECEASED NAME (TYPE OR PRINT) Susan Eileen Burch							2a. DATE KNOWN OF DEATH April 13 1985		2b. MONTH DAY YEAR		
3. SEX F	4. RACE W	5. DATE OF BIRTH March 31 1962		6. AGE (IN YEARS) 23 RS.	7. IF UNDER 1 YR. MONTHS DAYS	7. IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD April 13 1985		2d. MONTH DAY YEAR		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash. D.C.		7b. CITIZEN OF USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD.					
11. CITY OR TOWN OF DEATH Adelphi		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3408 Chatham Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Unemployed		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE MD		13b. COUNTY Prince Georges		13c. CITY OR TOWN Adelphi		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3408 Chatham Road		13f. CITY OR TOWN 20783	
14. FATHER'S NAME FIRST William MIDDLE F. LAST Burch				15. MOTHER'S MAIDEN NAME FIRST Catherine MIDDLE M. LAST Meyers							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) None				16b. SOCIAL SECURITY NO. 216-92-8665		17. INFORMANT ADDRESS William Burch (Father) Same as 13E					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Dis. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) Congenital Anomalies DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH (BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I) (a)											
19a. DATE OF OPERATION None				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE John Rogers		TITLE (SPECIFY) M.D.		MEDICAL EXAMINER John Rogers				DATE SIGNED April 13 1985			
EXAMINER'S NAME (TYPE OR PRINT) John Rogers, MD		ADDRESS 1919 Seminary Rd. S.S.Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/16/85		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven				23d. LOCATION CITY OR TOWN COUNTY S.S. Montgomery Md.			
24. FUNERAL DIRECTOR NAME Hines/Rinaldi ADDRESS 11800 New Hamp. Ave. S.S.Md.				25a. DATE REC'D. BY REGISTRAR APR 16 1985		25b. REGISTRAR'S SIGNATURE James Hines					

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Mildred F. Burley			2a. DATE OF DEATH MONTH DAY YEAR April 23, 1985		2b. HOUR 1:45 p.m.	
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR JUNE 12 1907		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash. D.C.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.		
10. CITY OR TOWN OF DEATH Largo	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Manor Care Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
13a. STATE Md.			13b. COUNTY PR. GEOS.	13c. CITY OR TOWN HYATTSVILLE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST ALONZO NORWOOD ESTES			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CARRIE MULLENS			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 577-30-7150			
17. INFORMANT JOYCE COLBERT			ADDRESS 7718 EMERSON RD. HYATTSVILLE, MD. 20784			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Acute congestive heart failure

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

Two days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

Arteriosclerotic cardiovascular disease**Unknown**

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from July 7 , 19 80 , to April 23 , 19 85 , that (I) (we) lost saw the deceased alive on April 23 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Jerald A. Reinshagen		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4-23-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jerald A. Reinshagen, M.D.		22e. ADDRESS 4404 Queensbury Road, Riverdale, Md. 20737					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE APR. 26, 1985		23c. NAME OF CEMETERY OR CREMATORY Ft. LINCOLN CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE BRENTWOOD P.G. Md.	
24. FUNERAL DIRECTOR NAME HOWARD. HALES LANHAM. F. #		ADDRESS 9013 ANNAPOLIS Rd. LANHAM, Md.		25a. DATE REC'D. BY REGISTRAR APR 30 1985		25b. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Julia A. Butuyan			2a. DATE OF DEATH MONTH DAY YEAR April 15, 1985			2b. HOUR 3:00 P.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Dec. 31, 1927		6. AGE (IN YEARS LAST BIRTHDAY) 57 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Indiana		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges County MD	
10. CITY OR TOWN OF DEATH Riverdale		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Leland Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. STATE Maryland				13b. COUNTY P.G.		13c. CITY OR TOWN Riverdale	
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS / ZIP CODE 6317 51st. Ave. 20737			
14. FATHER'S NAME FIRST MIDDLE LAST John P. Zimmer				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lona Thornton			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 317-28-7242		17. INFORMANT ADDRESS 14409 Long Green Dr. Silver Spring, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (b) Diabetes Mellitus DUE TO, OR AS A CONSEQUENCE OF (c) Nephrotic Syndrome Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (c)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 4/19 19 85 to 4/15 19 85 , that (I) (we) last saw the deceased alive on 4/12 19 85 , and that in (my) (our) opinion death occurred on the date of hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE 		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 4/16/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Abraham DABELA		22e. ADDRESS 4404 Queensbury Rd. Riverdale, MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Apr. 18, 1985		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood P.G. Maryland	
24. FUNERAL DIRECTOR NAME F. Gasch's Sons F.H. P.A. Hyattsville, Maryland				25a. DATE REC'D. BY REGISTRAR APR 18 1985		25b. REGISTRAR'S SIGNATURE 	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 2 2 0 5

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
FIRST MIDDLE LAST HOBSON M. CADY			MONTH DAY YEAR 04 13 85			HOURS MIN. 9.45^{am}		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		
Male	Caucasian	MONTH DAY YEAR Sept. 8 1919	65			MONTHS DAYS HOURS MIN. YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			
Washington, D.C.	U.S.A.				PRINCE GEORGES COUNTY MD.			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
CLINTON	SOUTHERN MARYLAND HOSPITAL			Gen. Contractor		Self-Employed		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13b. INSIDE CITY LIMITS?			13c. STREET ADDRESS / ZIP CODE		
13a. STATE COUNTY CITY OR TOWN Maryland Prince Georges Ft. Washington			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			9501 Livingston Rd. 20744		
14. FATHER'S NAME FIRST MIDDLE LAST Richard Henry Cady			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Katherine C. Massey					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes WWII			16b. SOCIAL SECURITY NO. 577-18-5051			17. INFORMANT ADDRESS Ruth P.E. Cady 9501 Livingston Rd. Ft. Washington, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Acute Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Arteriosclerotic Cerebrovascular Dis.; Chronic Obstructive Pulm. Dis. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Minutes Days Years								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			19c. AUTOPSY?		
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK OR NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (1) this hospital attended the deceased from 4/11 , 19 85 , to 4/13 , 19 85 , that (1) the last saw the deceased alive on 4/13 , 19 85 , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (2) we (did) not view the body after death.								
22b. SIGNATURE			DEGREE			22c. DATE SIGNED		
Dr. Louis Kaufman			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			4/13/85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS					
Dr. Louis Kaufman			8926 Woodyard Rd. Clinton MD 20735					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY		
Burial			4/16/85			Cedar Hill Cemetery		
						23d. LOCATION CITY OR TOWN COUNTY STATE Suitland P.G. Maryland		
24. FUNERAL DIRECTOR NAME			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
George P. Kalas Funeral Home Oxon Hill, Md.			APR 17 1985			via Davidson-Rendall		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Langston Hugh CALDWELL			2a. DATE OF DEATH MONTH DAY YEAR April 11, 1985		2b. HOUR 11:10P M
3. SEX Male	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR March 10, 1915		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Colorado	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George County MD.	
10. CITY OR TOWN OF DEATH LANHAM	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DOCTORS' HOSPITAL OF P.G. Co.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Dir. Physical Plant Hospital	12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Pennsylvania		13b. COUNTY Philadelphia	13c. CITY OR TOWN Philadelphia	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 262 Joseph's Way 99999
14. FATHER'S NAME FIRST MIDDLE LAST Wilbur Caldwell		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Inez Golson			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes		16b. SOCIAL SECURITY NO. 521-12-0662		17. INFORMANT Bowie, Maryland 20716 June C. Turner, sister, 1501 Pernell Court,	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic Obstructive Pulmonary Dis.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Pneumonia.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>NO</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (1) this hospital attended the deceased from <u>4/10/85</u> to <u>4/11/85</u> , that (1) <u>see</u> the deceased <u>alive</u> on <u>4/11/85</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above; (1) <u>yes</u> (add) <u>did not</u> see the body after death.					
22b. SIGNATURE <u>Stuart Turkewitz</u>		DEGREE <u>MD</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL STAFF <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Stuart Turkewitz</u>		22e. ADDRESS <u>7500 Greenway Ctr. Dr. Greenbelt, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Apr. 15, 1985	23c. NAME OF CEMETERY OR CREMATORY J. Wm. Lee's Sons		23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.
24. FUNERAL DIRECTOR NAME McGuire Funeral Service, Inc., Washington, DC.		7400 Georgia Ave. NW ADDRESS		25a. DATE REC'D. BY REGISTRAR APR 17 1985	25b. REGISTRAR'S SIGNATURE <u>Johia Davidson-Randall</u>

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. You may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

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WILSON



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Joseph CAMPBELL			2a. DATE OF DEATH MONTH DAY YEAR April 22, 1985		2b. HOUR 6:35pm	
3 SEX Male		4 RACE Black		5 DATE OF BIRTH MONTH DAY YEAR October 10, 1910		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		7b CITIZEN OF WHAT COUNTRY? U.S.A.		6 AGE (IN YEARS LAST BIRTHDAY) 74 YRS.		
10 CITY OR TOWN OF DEATH Lanham		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Doctors' Hospital of Pr. Geo. Co.		9 BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer		12b. KIND OF BUSINESS OR INDUSTRY Farming				
13a STATE Maryland		13b COUNTY P.G. Co.		13c CITY OR TOWN Lakeland		
14 FATHER'S NAME FIRST MIDDLE LAST Peter - Campbell		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Jane Covington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. 579-12-2729		17 INFORMANT ADDRESS Jessie Mae Campbell Same as # 13.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Staphylococcal Bacteremia DUE TO, OR AS A CONSEQUENCE OF (b) End Stage renal disease DUE TO, OR AS A CONSEQUENCE OF (c) Syphilitic Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:						
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, FARM ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) Dr. Abraham B. Davela attended the deceased from 4/11/85 to 4/22/85 , that (I) last saw the deceased alive on 4/22/85 , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) viewed the body after death.						
22b SIGNATURE Abraham B. Davela, M.D.		DEGREE		22c DATE SIGNED April/22/85		
22d PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS 4404 Queensbury Rd., Riverdale, Md. 20737				
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE Apr/27/85		23c NAME OF CEMETERY OR CREMATORY Maryland National Mem. Pk.		
23d LOCATION CITY OR TOWN COUNTY STATE Laurel, P.G. Co., Md.						
24 FUNERAL DIRECTOR NAME ADDRESS Chambers Funeral Home Riverdale, Maryland		25a DATE REC'D. BY REGISTRAR APR 25 1985				
		25b REGISTRAR'S SIGNATURE Jane Davidson-Randall				

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR												
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH					2b. HOUR		
John Walter CANNON					April 25, 1985					2:35 AM		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
MALE		CAUCASIAN		NOV 28, 1914			70 YRS.		MONTHS		DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH					
NORTH CAROLINA		U.S.A.					Prince George's MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK OR BUSINESS DURING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Lanham		Doctors' Hospital of Pr. Geo. Co.					ACCOUNTANT		BRAY & SCARFF SALES			
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE			
MARYLAND			PR. GEO		HYATTSVILLE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		2305 ERSKINE STREET 20783			
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME							
JOSEPH L. CANNON					GRACE L. CORNELIUS							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO		17. INFORMANT ADDRESS					
YES					WW II		ESTHER M. CANNON SAME AS 13 WIFE					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gram Negative Sepsis</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <u>Chronic Renal failure, acute valvular Disease</u>												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (the hospital) attended the deceased from <u>4/24</u> , 19 <u>85</u> , to <u>4/25</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>4/24</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (we) (I) did not view the body after death.												
22b. SIGNATURE					22c. DATE SIGNED							
<u>[Signature]</u>					<u>MD</u>					4/25/85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS							
POLLAK					4700 AUTH PLACE, CAMP SPRINGS							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE				
CREMATION			4/26/85		METROPOLITAN			ALEXANDRIA VIRGINIA				
24. FUNERAL DIRECTOR NAME					25. BY REGISTERAR		25b. REGISTRAR'S SIGNATURE					
FRANCIS J. COLLINS					MAY 1 1985		<u>[Signature]</u>					
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901												

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) CORINNE BEATRICE CASH			2a. DATE OF DEATH MONTH DAY YEAR APRIL 22 1985			2b. HOUR 9:15A M			
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR Oct. 1, 1900		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.			
10. CITY OR TOWN OF DEATH Lanham		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Doctors' Hospital of Pr. Geo. Co.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY At Home	
13a. STATE Md.			13b. COUNTY P.G.		13c. CITY OR TOWN Glen Arden		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Fred Hall			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown			13e. STREET ADDRESS / ZIP CODE 8611 Glen Arden Pkwy. 21057			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 217-09-5882		17. INFORMANT ADDRESS Rogers Cash-Same as # 13 above				

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) *Cardiac arrest*

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

DUE TO, OR AS CONSEQUENCE OF

(b) *Myocardial infarction*

DUE TO, OR AS CONSEQUENCE OF

(c) *Interosseous heart disease 10 yrs*PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:
Chronic obstructive pulmonary disease

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
19c. AUTOPSY
YES ☐ NO ☒
20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED
WHILE ☐ AT WORK NOT WHILE ☐ AT WORK
21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION
STREET CITY OR TOWN COUNTY STATE

22a. I certify that (1) this hospital attended the deceased from Jan 1985 to Apr 22 1985, that (1) (we) last saw the deceased on Apr 13 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) see the body after death.

22b. SIGNATURE
DEGREE
22c. DATE SIGNED
4-22-85
ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Ronald P. Hairson, M.D.
22e. ADDRESS
6910 Columbia Park Rd., Landover, Md. 20785

23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
23b. DATE
4/27/85
23c. NAME OF CEMETERY OR CREMATORY
HARMONY MEM. PARK
23d. LOCATION
CITY OR TOWN COUNTY STATE
HIGHLAND PARK P.G. MD.

24. FUNERAL DIRECTOR
NAME
H.S. WASHINGTON & SONS 4925 BURROUGHS AVE., N.E.
25a. DATE REC'D. BY REGISTRAR
MAY 1 1985
25b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST CARLTON		MIDDLE R.	LAST CASSIDY		2a. DATE OF DEATH MONTH DAY YEAR 4 7 1985		2b. HOUR 10:42 P.M.		
3 SEX Male		4 RACE Caucasian		5 DATE OF BIRTH MONTH DAY YEAR December 15, 1912		6 AGE (IN YEARS LAST BIRTHDAY) 72		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD.					
10 CITY OR TOWN OF DEATH CLINTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern MD Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Electrician		12b. KIND OF BUSINESS OR INDUSTRY Electric - Union			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a STATE Maryland		13b COUNTY Prince George's		13c CITY OR TOWN Clinton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 6802 Pamela Lane (20735)	
14 FATHER'S NAME FIRST MIDDLE LAST Charlie Cassidy				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Carrie G. Smith							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII		17 INFORMANT ADDRESS Emma S. Cassidy - Same As #13 A-E							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF (b) myocardial infarct DUE TO, OR AS A CONSEQUENCE OF (c) Coronary Heart Disease. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:10											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from Dec 1974 to 4-7-1985, that (I) (we) last saw the deceased alive on 4-7-1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.											
22b. SIGNATURE G.S. RATH				DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 4-7-85			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) G.S. RATH				22e. ADDRESS SUITE 207 CHARLES PROFESSIONAL BLDG., WALDORF, MD. 20601							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE April 11, 1985		23c. NAME OF CEMETERY OR CREMATORY Quantico National Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Quantico, Virginia					
24. FUNERAL DIRECTOR NAME Lee Funeral Home, Inc.				25a. DATE REC'D. BY REGISTRAR APR 9 1985				25b. REGISTRAR'S SIGNATURE in Davidson-Randall			
ADDRESS 1633 Old Alexander Ferry Road, Clinton, Maryland											

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed within 72 hours after death. This certificate should be detached for use as the burial-transit permit. Then please remove carbon-copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

1011



112046

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM VM-3. RETAIN PAGE 5 FOR YOURS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) William Chase						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 4 5 19 85		7b. HOUR M			
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR Sept. 14, 1964 20 YRS.		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 4 5 19 85		7d. HOUR 9:40	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George MD					
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince George General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Unemployed		12b. KIND OF BUSINESS OR INDUSTRY None			
13a. STATE Md.		13b. COUNTY P.G.		13c. CITY OR TOWN Palmer Park		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2308 Matthew Benson Ave.			
14. FATHER'S NAME FIRST MIDDLE LAST Rudolph Chase						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Agnes Jones					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. Unknown		17. INFORMANT ADDRESS Agnes Chase-Same as # 13 above					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Stab wound of chest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 8:54 PM 4/5 19 85		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject stabbed					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Plaza		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Dodge Plaza, Prince Geo Co, MD					
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>Margarita A. Korell</i>				TITLE (SPECIFY) M.D. Assistant				DATE SIGNED 4/6/85			
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.				ADDRESS 111 Penn Street, Baltimore, MD 21201							
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE 4/12/85		23c. NAME OF CEMETERY OR CREMATORY HARMONY MEM. PARK		23d. LOCATION CITY OR TOWN COUNTY STATE LANDOVER, P.G., MD.			
24. FUNERAL DIRECTOR NAME ADDRESS H.S. WASHINGTON & SONS 4925 BUNNINGS AVE, W.F.						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			

07/84
25MBP
DHMH - 17
(VR A15 ME (15))APR 17 1985 *Julia Dandrea-Randall*

11005

Black Sept. 17, 1960 20

U.S.A. No.

Unassigned 2005 Madison Avenue
R.D. Palmer Park 2

Unknown
Green
Amos
Jones
Amos Green-Same as 13 above

205 COLUMBIA

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

120073

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Roy A CHEW			2a. DATE OF DEATH MONTH DAY YEAR 04 18 85		2b. HOUR 9:11 P.M.	
3. SEX Male		4. RACE Cauc.		5. DATE OF BIRTH MONTH DAY YEAR 4 26 08		
6. AGE (IN YEARS LAST BIRTHDAY) 76		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey		8. CITIZEN OF WHAT COUNTRY? USA		
9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S MD.		10. CITY OR TOWN OF DEATH CLINTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Md. Hospital		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY Traffic Director		13. STREET ADDRESS / ZIP CODE 4319 Sheldon Ave. 20748		
14. FATHER'S NAME FIRST MIDDLE LAST Claud L. Chew		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary A. Cartin		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		
17. SOCIAL SECURITY NO. 577-10-1512		18. INFORMANT Katherine L. Chew same as item 13		19. ADDRESS		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiomyopathy Arrest ASD, MR</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Ventricular Tachy Cardia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Pericardial effusion</u>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:						
19a. DATE OF OPERATION 4-13-85		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED appendicitis cholecystitis		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)		
21d. INJURY OCCURRED 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from 4-9-85 to 4-18-85, that (I) (we) lost saw the deceased alive on 4-18-85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.		
22b. SIGNATURE Abul Hasan Ali		22c. ADDRESS 8926 Woodland Rd #101 Clinton Md 20735		22d. DATE SIGNED 4-19-85		
22e. PHYSICIAN'S NAME (TYPE OR PRINT) ABUL HASAN U ANSARI		22f. ADDRESS 8926 Woodland Rd #101 Clinton Md 20735		22g. DATE SIGNED 4-19-85		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/22/85		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		
23d. LOCATION SUITLAND P.G. MD.		23e. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23f. LOCATION SUITLAND P.G. MD.		
24. FUNERAL DIRECTOR NAME G.P. Kalas 6160 Oxon Hill Rd. Oxon Hill, Md.		25a. DATE REC'D BY REGISTRAR APR 24 1985		25b. REGISTRAR'S SIGNATURE Davidson-Randall		

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

• CMC.

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120938

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows injury, or other traumatic event, the medical examiner must be notified.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST GOLDIE JANE CHUMBRIS			2a. DATE OF DEATH MONTH DAY YEAR APRIL 22 1985		2b. HOUR 9:50A M
3 SEX Female	4 RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR July 2, 1922		6 AGE (IN YEARS LAST BIRTHDAY) 62 YRS IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS: HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD	
10. CITY OR TOWN OF DEATH Lanham	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Doctors' Hospital of Pr. Geo. Co.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Hostess		12b. KIND OF BUSINESS OR INDUSTRY Restaurant
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Maryland Prince Georges Bowie			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 12702 Beaverdale Lane 20715
14 FATHER'S NAME FIRST MIDDLE LAST Russell Shaffer			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Carrie Jane Miller		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no		16b. SOCIAL SECURITY NO. 220-12-8085		17 INFORMANT ADDRESS Andrew S. Chumbris same as 13e	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (b) coronary artery disease DUE TO, OR AS A CONSEQUENCE OF (c) CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Hypertension					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 4/22 1985 to 4/22 1985 , that (I) (we) last saw the deceased alive on 4/22/85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE R. Dakheel		DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/22/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Riad Dakheel, M.D.		22e. ADDRESS 14300 Gallant Fox Ln. Bowie, MD 20715			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE April 25 1985		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, Maryland					
24 FUNERAL DIRECTOR NAME Beall Funeral Home		24b. ADDRESS 16000 Annapolis Rd. Bowie, Maryland		25a. DATE REC'D. BY REGISTRAR APR 23 1985	
25b. REGISTRAR'S SIGNATURE [Signature]					

BP

150938

Female
Maryland

Constitution
USA

July 2, 1922
X

Houston

Residence

Maryland

Prince George's County

X

13705 Pennsylvania Lane (SU13)

Russell

Marion

Carrie

Jane

Miller

on

220-12-00 Andrew L. Chavira

born on 1/2

These are the names of the children of the above named person.

1900 Census

Marion, Carrie, Jane, Miller

120939

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

Medical Examiner Notified & Released

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and complete page 2.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR							
1. DECEASED NAME (TYPE OR PRINT) George S. Clark				2a. DATE OF DEATH MONTH DAY YEAR April 18, 1985		2b. HOUR 5:00P.M.	
3 SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR February 1, 1922		6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Minnesota		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George MD.	
10. CITY OR TOWN OF DEATH West Lanham		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 7809 Cross Street		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Painter		12b. KIND OF BUSINESS OR INDUSTRY Contracting Co.	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY P.G. 13c. CITY OR TOWN West Lanham				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 7809 Cross Street 20706	
14. FATHER'S NAME FIRST MIDDLE LAST William Arthur Clark				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bessie Lou (Unknown)			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) unknown		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 477 34 6020		17. INFORMANT ADDRESS Betty L. Clark same as 13 e			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>heart failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>chronic pulmonary disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>APR 31 1985</u> to <u>April 18 85</u> that (I) (we) last saw the deceased alive on <u>APR 31 1985</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If not, (I) (we) did) (did not) visit the person after death.						22b. SIGNATURE <u>David J. Haidak</u> DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (TYPE OR PRINT) David J. Haidak				22e. ADDRESS 7801 Old Branch Ave. #410 Clinton, Md. 20735			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4-22-85		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood. P.G. Maryland	
24. FUNERAL HOME NAME ADDRESS Francis Gasch's Sons Funeral Home P.A. 4739 Baltimore Avenue Hyattsville, Md. 20781				25a. DATE OF REGISTRATION APR 23 1985 25b. REGISTRAR'S SIGNATURE <u>David J. Haidak</u>			

120939

Continental & North American Journal

April 15, 1982

DATA

Continental

Prince George

1980 Cross Street



1981

105133

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 10.3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25MBP
DHMH - 17
(VR A15 ME (5))1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE KNOWN OF DEATH			2b. DATE ESTI- MATED			2c. DATE PRONOUNCED			2d. HOUR		
FIRST MIDDLE LAST Robert A. Clark			MONTH DAY YEAR 4-2 1985			MONTH DAY YEAR 4-2 1985			MONTH DAY YEAR 4-2 1985			M		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 5-26 30		6. AGE (IN YEARS) LAST BIRTHDAY 54 YRS.		7. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN		8. MARRIED NEVER MARRIED WIDOWED DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington DC		7b. CITIZEN OF WHAT COUNTRY? USA		10. CITY OR TOWN OF DEATH Clinton		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Maryland Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Manager		12b. KIND OF BUSINESS OR INDUSTRY Safeway				
13a. STATE Maryland		13b. COUNTY Pr George		13c. CITY OR TOWN Forestville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3608 Melrose Ave 20747						
14. FATHER'S NAME FIRST MIDDLE LAST James Edward Clark			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Ellen Long			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. 1959 218 24 3278			17. INFORMANT Barbara A Clark Same as #13		
18. CAUSE OF DEATH (Enter only one cause per (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pleuritic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).														
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .														
ACTUAL SIGNATURE <u>Augusto P. Rodriguez</u>				TITLE (SPECIFY) M.D. Deputy				MEDICAL EXAMINER				DATE SIGNED 4-3-85		
EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez, M.D.				ADDRESS 5009 Rayburn Ct., Temple Hills, Md										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 5 April 1985		23c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery Clinton				23d. LOCATION CITY OR TOWN COUNTY STATE PG Md				
24. FUNERAL DIRECTOR NAME Robert E Wilhelm Funeral Home				ADDRESS Suitland, Md.				DATE REC'D BY REGISTRAR APR 10 1985				REGISTRAR'S SIGNATURE Julia Davidson-Rodriguez		



130015

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- STATE REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		7b. HOUR			
Henry Lewis Clay								April 26, 1988								1244			
1. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR			
Male	White	03 22 1913		72						April 26, 1988									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		WIDOWED		DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH							
West Virginia		U.S.A.														Prince George's County			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12. USUAL OCCUPATION (TYPE OF WORK)		12b. KIND OF BUSINESS OR INDUSTRY													
Riverdale		Leland Memorial Hospital		Retired		Cab Driver		Yellow Cab Co											
13a. STATE		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13d. STREET ADDRESS													
Maryland		P.G.		Hyattsville		YES		3910 Nicholson Street 20782											
14. FATHER'S NAME		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME		MIDDLE		LAST									
Howard		F.		Clay		Eva				Hysell									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		3910 Nicholson Street													
Yes-Army		W.W.II		235-05-5014		Harold Clay (Son)		Hyattsville, Md. 20782											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
				Acute Myocardial Dist															
				(b)		DUE TO, OR AS A CONSEQUENCE OF													
				(c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:		None																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?															
None		None		YES		NO													
21a. EXTERNAL CAUSE WAS		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED		ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2													
UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		HOUR A.M. MONTH DAY YEAR																	
		P.M. 19																	
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION		CITY OR TOWN COUNTY STATE													
WHILE AT WORK NOT WHILE AT WORK																			
22a. I certify that I took charge of the remains described above, held on		Autopsy		Inspection		Inquiry		and in my opinion											
death resulted from:		Natural causes		Accident		Suicide		Homicide		Undetermined manner									
ACTUAL SIGNATURE		TITLE (SPECIFY)		MEDICAL EXAMINER		DATE SIGNED													
John S. Rogers, M.D.		M.D. Dep.				April 26, 1988													
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS		1919 Seminary Rd. Silver Spring, MD															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		COUNTY		STATE									
Cremation		4/29/85		Fort Lincoln Crematory		Brentwood		P.G.		Maryland									
24. FUNERAL HOME (NAME AND ADDRESS)		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE															
Francis Casch's Sons Funeral Home, P.A. 4739 Baltimore Avenue Hyattsville, Md. 20781		MAY 8 1985		J. W. Anderson-Randall															

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR OR TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER. TRANSIT PERMIT: PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25MBP
DHMH - 17
(VR A15 ME (5))



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

106144

1. DECEASED NAME (TYPE OR PRINT)		FIRST OLIVER	MIDDLE C.	LAST CLINTON	2a. DATE OF DEATH		MONTH 04	DAY 04	YEAR 85	2b. HOUR 7 00AM	
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR Nov. 9, 1912		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S. Carolina		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES COUNTY MD.					
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGES GENERAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired - Post Office		12b. KIND OF BUSINESS OR INDUSTRY Office			

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 411 Quarry Place 20743		
13a. STATE Maryland	13b. COUNTY PG	13c. CITY OR TOWN Cap. Hqts.						

14. FATHER'S NAME FIRST MIDDLE LAST Coyt Clinton			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jeannette Witherspoon		
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16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 579 12 722B		17. INFORMANT ADDRESS 411 Quarry Place-Capitol Heights, Md. Clauges Clinton-wife	
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MYELO-MONOCYTIC LEUKIMIA DUE TO, OR AS A CONSEQUENCE OF (b) INTESTINAL OBSTRUCTION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) ACUTE MYOCARDIAL INFARCTION		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: CELLULITIS			
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19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
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21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
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21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
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22a. I certify that (I) (this hospital) attended the deceased from 3. 5. 19 85, to 4. 4. 19 85, that (I) (we) last saw the deceased alive on 4. 3. 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
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22b. SIGNATURE V. P. Singh		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4. 5. 85	
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22d. PHYSICIAN'S NAME (TYPE OR PRINT) V. P. SINGH		22e. ADDRESS 5632 ANNAPOLIS RD # 9 BLADENSBURG MD. 20710					
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23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE April 11 1985		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood, Maryland	
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24. FUNERAL DIRECTOR NAME Stewart		25a. DATE REC'D. BY REGISTRAR APR 11 1985		25b. REGISTRAR'S SIGNATURE [Signature]	
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and the medical examiner must be present at the autopsy.

1 2 2 1 8

1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
Billy H. Clubb, Sr.				04 15 85		12:40 AM			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
Male		Caucasian		MONTH DAY YEAR Sept. 27 1927		57 YRS		IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10. IF UNDER 24 HRS	
North Carolina		U.S.A.				PRINCE GEORGE'S MD.			
11. CITY OR TOWN OF DEATH		12. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT INSURE FACILITY, GIVE STREET ADDRESS)		13. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		14. KIND OF BUSINESS OR INDUSTRY		15. Roofing	
CLINTON		Southern Md Hospital		Roofing Contractor		Roofing			
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		17. STATE		18. CITY OR TOWN		19. INSIDE CITY LIMITS?		20. STREET ADDRESS / ZIP CODE	
Maryland		Prince George		Forest Hgts.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		5907 Blackhawk Drive 20745	
21. FATHER'S NAME		22. MOTHER'S MAIDEN NAME		23. INFORMANT		24. ADDRESS		25. Temple Hills, Md. 20748	
Arthur Clubb		Gladys Rhymmer		Billy Clubb		6012 St. Moritz Drive			
26. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		27. SOCIAL SECURITY NO.		28. DATE OF OPERATION		29. CONDITION FOR WHICH OPERATION WAS PERFORMED		30. AUTOPSY?	
Yes		WWII		248-24-0562				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
31. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:		32. IMMEDIATE CAUSE (a)		33. DUE TO, OR AS A CONSEQUENCE OF		34. (b)		35. DUE TO, OR AS A CONSEQUENCE OF	
Metastatic Carcinoma of Urinary L. bladder.									
36. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:									
37. DATE OF OPERATION		38. TIME OF INJURY		39. HOW INJURY OCCURRED		40. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		41. DATE SIGNED	
4-13-85		P.M. 19		4-13-85		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		4-15-85	
42. SIGNATURE		43. PHYSICIAN'S NAME (TYPE OR PRINT)		44. ADDRESS		45. DATE REC'D. BY REGISTRAR		46. REGISTRAR'S SIGNATURE	
H.A. Barakat M.D.		HASSAN A. BARAKAT		9440 Marlboro Pike #320 Upper Marlboro MD 20772		APR 17 1985		[Signature]	
47. BURIAL, CREMATION, REMOVAL (SPECIFY)		48. DATE		49. NAME OF CEMETERY OR CREMATORY		50. LOCATION		51. STATE	
Burial		4/17/85		Maryland Veterans Cem.		Cheltenham P.G. Maryland			
52. FUNERAL DIRECTOR		53. DATE		54. NAME OF CEMETERY OR CREMATORY		55. LOCATION		56. STATE	
George P. Kalas Funeral Home		4/17/85		Oxon Hill, Md.		Cheltenham P.G. Maryland			

BP

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) George E. Coburn			2a. DATE OF DEATH MONTH DAY YEAR April 29, 1985		2b. HOUR 2:45A.M.
3. SEX male	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR October 23, 1914	6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS	7. UNDER 1 YEAR MONTHS DAYS	8. UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.		
10. CITY OR TOWN OF DEATH Laurel	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greater Laurel Beltsville Hospital		12a. USUAL OCCUPATION (TYPE OF WORK, NAME OF WORKING PLACE) disabled veteran		12b. KIND OF BUSINESS OR INDUSTRY U S Army
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md			13b. CITY OR TOWN Laurel	13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13d. STREET ADDRESS / ZIP CODE 8489 Heatherwold Drive 20707
14. FATHER'S NAME FIRST MIDDLE LAST George Henry Coburn			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Miller		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW 2 321 10 2314	17. INFORMANT ADDRESS Margaret Coburn same as above		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) VENTRICULAR ARRHYTHMIA DUE TO, OR AS A CONSEQUENCE OF (b) CORONARY ARTERY DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) PULMONARY FIBROSIS, ANGINA, CONGESTIVE HEART FAILURE					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: PULMONARY FIBROSIS, ANGINA, CONGESTIVE HEART FAILURE					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (which did not) view the body after death.					
22b. SIGNATURE <i>[Signature]</i>		DEGREE MD		22c. DATE SIGNED 4/24/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ESMALHADO		22e. ADDRESS 321 PRINCE GEORGE ST			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE May 1, 1985	23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood, Md	
24. FUNERAL DIRECTOR NAME Donaldson Funeral Home, Laurel, Md		25a. DATE REC'D. BY REGISTRAR MAY 09 1985		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

MEDICAL CERTIFICATION

70
84
35
30
129
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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and carefully filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



109117

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGE 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 10. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17
(VR A15 ME (5))FOR
1- STATE
REGISTRAR
 STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST <i>Benjamin</i>		MIDDLE <i>Cohen</i>		LAST <i>Cohen</i>		2a. DATE KNOWN OF DEATH MONTH <input checked="" type="checkbox"/> DAY YEAR		2b. HOUR	
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>May 10, 1909</i>		6. AGE (IN YEARS) (LAST BIRTHDAY) <i>75</i> YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED MONTH DAY YEAR <i>4-8 1985</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Russia</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		7. BALTIMORE CITY OR COUNTY OF DEATH <i>Prince George's County, MD</i>					
10. CITY OR TOWN OF DEATH <i>Cheverly</i>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Prince Georges General Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Electrician (Ret.)</i>				12b. KIND OF BUSINESS OR INDUSTRY <i>Construction</i>	
13. STATE <i>Florida</i>						13b. COUNTY <i>Broward</i>		13c. CITY OR TOWN <i>Deerfield Beach</i>		13d. INSIDE CITY LIMITS? <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Unknown COHEN</i>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Unknown</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>NO</i>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>102-05-5899</i>		17. INFORMANT ADDRESS <i>20715 Sheila Beram; 12606 Safety Turn; Bowie, Md.</i>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE IN <i>Arteriosclerotic cardiovascular disease</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>Augusto P. Rodriguez</i>				TITLE (SPECIFY) <i>Deputy</i>				DATE SIGNED <i>4-8-85</i>			
EXAMINER'S NAME (TYPE OR PRINT) <i>Augusto P. Rodriguez, M.D.</i>				ADDRESS <i>5009 Rayburn Ct., Temple Hills, Md</i>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>				23b. DATE <i>4/9/85</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Golda Cemetery</i>				23d. LOCATION CITY OR TOWN COUNTY STATE <i>Huntington Station, New York</i>	
24. FUNERAL DIRECTOR NAME <i>DANZANSKY-GOLDBERG MEMORIAL CHPLS</i>				25a. DATE REC'D. BY REGISTRAR <i>APR 15 1985</i>				25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			
1170 Rockville Pike; Rockville, Md. 20852											

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1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JULIA M. COLBERT			2a. DATE OF DEATH MONTH DAY YEAR 03-27-85		2b. HOUR 12 :40AM			
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 7 10 95		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 89		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD.		
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S GENERAL HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY None	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)								
13a. STATE Md		13b. COUNTY Prince Georges		13c. CITY OR TOWN Upper Marl		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST John Quinicy Adams				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 219-36-8197		17. INFORMANT ADDRESS Josh Scribner 15119 Peerless Avenue Upper Marlboro, MD 20772				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>As this patient could not be drawn</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) this hospital attended the deceased from <u>4/1/85</u> to <u>3/27/85</u> , that (II) (we) last saw the deceased alive on <u>3/26/85</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I/we) (did not) see the body after death.								
22b. SIGNATURE <u>A. C. Holmes M.D.</u>				DEGREE <u>M.D.</u>		22c. DATE SIGNED <u>3/27/85</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A. C. HOLMES M.D.				22e. ADDRESS 14314 OLD MARLBORO PIKE UPPER MARLBORO, MD				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/1/85		23c. NAME OF CEMETERY OR CREMATORY Rollins Funeral Home, Inc. Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Landover Prince George's MD		
24. FUNERAL DIRECTOR NAME ROLLINS FUNERAL HOME, INC. 4339 HUNT PLACE, N.E. WASHINGTON, D.C. 20019				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>Julia Swanson-Randall</u>		

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ROLLING FUNERAL HOME, INC.
4330 HUNT PLACE, N.E.
WASHINGTON, D.C. 20019

CONSENT

PRINCE GEORGE'S COUNTY

PRINCE GEORGE'S GENERAL HOSPITAL

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <i>Florence L. Coleman</i>			2a. DATE KNOWN OF DEATH MATED <i>4-8-85</i>		2b. HOUR M <i>12</i>
3. SEX <i>Female</i>	4. RACE <i>White</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>March 13, 1903</i>	6. AGE (IN YEARS LAST BIRTHDAY) <i>82</i> YRS.	IF UNDER 1 YR MONTHS DAYS HOURS MIN	IF UNDER 24 HRS.
BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Penna.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Pr. Geo.</i>
10. CITY OR TOWN OF DEATH <i>Dargo</i>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>12006 Wimpleton St.</i>		12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) <i>Ret. Registered Nurse-</i>	12b. KIND OF BUSINESS OR INDUSTRY
13a. RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <i>Maryland</i> COUNTY <i>Montgomery</i> CITY OR TOWN <i>Damascus</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <i>25809 Ridge Road</i> 20872		
14. FATHER'S NAME FIRST MIDDLE LAST <i>Frank Lentz</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Florence Leib</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>578-42-2426</i>		17. INFORMANT <i>Edward D. Coleman</i> ADDRESS <i>12006-Wimpleton St., Upper Marlboro, Md.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic cardiovascular disease</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE <i>Augusto P. Rodriguez</i>		TITLE (SPECIFY) <i>Deputy</i>		DATE SIGNED <i>4-8-85</i>	
EXAMINER'S NAME (TYPE OR PRINT) <i>Augusto P. Rodriguez, M.D.</i>		ADDRESS <i>5009 Rayburn Ct., Temple Hills, Md</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>	23b. DATE <i>4/11/1985</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Olivet Cem.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Wash., D.C.</i>	
24. FUNERAL DIRECTOR'S NAME <i>Valley's F.H. Inc.</i>		ADDRESS <i>Mt. Rainier, Md.</i>		25a. DATE REC'D. BY REGISTRAR <i>APR 16 1985</i>	
				25b. REGISTRAR'S SIGNATURE <i>John B. ...</i>	

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(VR A15 ME (5))

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FRANK A COLLINS			2a. DATE OF DEATH MONTH 4 DAY 16 YEAR 85		2b. HOUR 6.15pm M
3. SEX Male	4. RACE Black	5. DATE OF BIRTH MONTH 7 DAY 13 YEAR 18		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		9b. CITIZEN OF WHAT COUNTRY? U.S.A.		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES COUNTY MD.	
10. CITY OR TOWN OF DEATH CLINTON MD		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION SOUTHERN MARYLAND HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cement Finisher	
12b. KIND OF BUSINESS OR INDUSTRY P.G. Public Works					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE MD	13b. COUNTY P.G.	13c. CITY OR TOWN Forestville	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 2200 Ritchie Road 20747	
14. FATHER'S NAME FIRST Nathan MIDDLE Collins LAST Collins		15. MOTHER'S MAIDEN NAME FIRST Martha MIDDLE Wilson LAST Wilson			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 238-22-3669		17. INFORMANT Elizabeth Rutland ADDRESS 2200 Ritchie Road Forestville, MD 20747	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) INFLAMMATORY Bowel Disease DUE TO, OR AS A CONSEQUENCE OF: (b) Pseudomonas Urinary Tract Infection DUE TO, OR AS A CONSEQUENCE OF: (c) Cachexia secondary to ID APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Diagnosis ch. w. 11					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 0					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1; OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from Nov 1983 to Apr 1985 , that (I) (we) lost saw the deceased alive on April 16 1985 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Harry Katzman MD		DEGREE MD		22c. DATE SIGNED 4/17/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HARRY KATZMAN MD		22e. ADDRESS 8926 Woodward Rd Clinton, MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/23/85		23c. NAME OF CEMETERY OR CREMATORY Landover Prince Georges Memorial Park	
23d. LOCATION CITY OR TOWN COUNTY STATE Landover Prince Georges MD					
24. FUNERAL DIRECTOR NAME ROLLINS FUNERAL HOME 4339 HUNT PLACE, N.E. WASHINGTON, D.C. 20019					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or, item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

11

Handwritten notes and stamps, including a large circular stamp with the number 11 in the center. The text is mostly illegible due to fading and bleed-through.

ROLLING FINANCIAL HOME, INC.
4120 HILL BLVD.
W. 10010

1- FOR
STATE
REGISTRAR

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST Kevin			MIDDLE M.			LAST Cook			2a. DATE KNOWN OF DEATH ESTI- MATED <input checked="" type="checkbox"/> MONTH DAY YEAR			2b. HOUR M					
3. SEX Male			4. RACE White			5. DATE OF BIRTH MONTH DAY YEAR 11-15-1956			6. AGE (IN YEARS) (LAST BIRTHDAY) 28 YRS.			IF UNDER 1 YR MONTHS DAYS HOURS MIN			7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 4 21 19 85			2d. HOUR M 12:14		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County, MD.											
10. CITY OR TOWN OF DEATH Laurel			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greater Laurel/Beltsville Hospital						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Disabled			12b. KIND OF BUSINESS OR INDUSTRY -								
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																				
13a. STATE Md.			13b. COUNTY Harford			13c. CITY OR TOWN Joppa			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS 104 Driftwood Ct. 21085								
14. FATHER'S NAME FIRST MIDDLE LAST Morgan L. Cook						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eleanor Larrimore														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no						16b. SOCIAL SECURITY NO. 219-58-3650			17. INFORMANT ADDRESS Eleanor Cook (mother) same address											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Neuroleptic Malignant syndrome</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying cause last</u> . (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																				
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?																	
19c. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																				
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)														
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE														
22a. I certify that I took charge of the remains described above, held on death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accidents <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion																				
ACTUAL SIGNATURE <u>Thomas D. Smith</u>			TITLE (SPECIFY) Acting Chief						DATE SIGNED 4/21/85											
EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D.			ADDRESS 111 Penn St. Balto.MD.																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 4/25/85			23c. NAME OF CEMETERY OR CREMATORY Spedden-Seward			23d. LOCATION CITY OR TOWN COUNTY STATE Hutson Md.											
24. FUNERAL HOME NAME SCHTMUNEK FUNERAL HOME INC. 7905 Belair Rd. Balto. Md. 21236						25a. DATE REC'D. BY REGISTRAR APR 23 1985			25b. REGISTRAR'S SIGNATURE <u>Davidson</u>											

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

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1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) JOSEPH E. CRANFORD.			2a. DATE OF DEATH MONTH DAY YEAR 4 7 1985			2b. HOUR 4:44 P.M.			
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR March 6 1928		6. AGE (IN YEARS LAST BIRTHDAY) 57 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE MD.			
10. CITY OR TOWN OF DEATH CLINTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) So. mo. Hosp. Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Projectionist-Ret.		12b. KIND OF BUSINESS OR INDUSTRY Motion Picture	
13a. STATE Maryland			13b. COUNTY Anne Arundel		13c. CITY OR TOWN Harwood		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST William M. Cranford			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Edna Wheatley			13e. STREET ADDRESS / ZIP CODE 4749 L Flanders Lane 20776			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218-20-0695		17. INFORMANT ADDRESS Doris L. Cranford 4749 L Flanders Lane Harwood, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Emphysema. DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from June 1982 to 4-7-1985 , that (I) (we) last saw the deceased alive on 4-7-1985 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (not) view the body after death.									
22b. SIGNATURE G.S. RATH				DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 4/7/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) G. S. RATH				22e. ADDRESS CHARLES PROFESSIONAL BLDG, WALDORF Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/10/85		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood P.G. Maryland			
24. FUNERAL DIRECTOR NAME Gene Rala		25a. DATE REC'D BY REGISTRAR 6160-00000000		25b. REGISTRAR'S SIGNATURE APR 11 1985					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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**STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH**

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Robert E CROWEL			2a. DATE OF DEATH MONTH DAY YEAR 4-28-85		2b. HOUR 6:19A.M.	
3. SEX male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 12 26 26		
6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS.		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio		8. CITIZEN OF WHAT COUNTRY? U.S.A.		
9. BALTIMORE CITY OR COUNTY OF DEATH Prince George MD.		10. CITY OR TOWN OF DEATH Clinton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Maryland Hosp. Center		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Salesman		12b. KIND OF BUSINESS OR INDUSTRY Krispy Kreme Donuts		13a. STREET ADDRESS / ZIP CODE 1709 Taylor Ave 20744		
14. FATHER'S NAME FIRST MIDDLE LAST George Crowel		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marie Lowe		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		
16b. SOCIAL SECURITY NO. W.W.II		16c. SOCIAL SECURITY NO. 287 222 891		17. INFORMANT Anne T. Crowel		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral anoxia of lung DUE TO, OR AS A CONSEQUENCE OF (b) Chronic obstructive pulmonary DUE TO, OR AS A CONSEQUENCE OF (c) disease, Cardiac arrest.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (the hospital) attended the deceased from March 26 , 19 85 , to April 28 , 19 85 , that (I) was lost saw the deceased alive on April 18 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) was (did) view the body after death.						
22b. SIGNATURE M. Taleghani				22c. DATE SIGNED 4-28-85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) M. Taleghani M.D.				22e. ADDRESS 4467 Old Branch Ave. Temple Hills, Md. 20748		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5-1-85		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery Brentwood Pr. Geo. Md.		
23d. LOCATION CITY OR TOWN COUNTY STATE		23e. DATE REC'D. BY REGISTRAR		23f. REGISTRAR'S SIGNATURE Eric Davidson-Randell		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies, pages 1 and 2, and 3 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



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STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Minnie ✓ Crusan			2a. DATE OF DEATH MONTH DAY YEAR April 10 85			2b. HOUR 1035 P.M.				
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Sept. 27 1897		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.				
10. CITY OR TOWN OF DEATH Ft. Washington		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Ft. Washington Rehabilitation Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY N/A		
13a. STATE Maryland			13b. COUNTY Prince George's		13c. CITY OR TOWN Marlow Heights		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2410 Olson St. 20748	
14. FATHER'S NAME FIRST MIDDLE LAST Edward L. Hill			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Frances Ann Elizabeth Clubb							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 579-05-7097		17. INFORMANT ADDRESS 2410 Olson St. Clarence R. Crusan Marlow Heights, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-pulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Fatal Arrhythmia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arterio sclerotic Cardiovascular Dis. 10 years.</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 mins.</u> <u>5 mins.</u>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Atrial Fibrillation, Hx of Acute Pulm. Emboli 1983, Severe Dementia</u>										
19a. DATE OF OPERATION <u>N.A.</u>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>N.A.</u>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <u>N.A.</u>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>12/5</u> 19 <u>83</u> to <u>4/10</u> 19 <u>85</u> , that (I) (we) lost saw the deceased alive on <u>3/27</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Richard A. Farson MD</u>						22c. DATE SIGNED <u>4/11/85</u>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Richard A. Farson, MD.</u>						22e. ADDRESS <u>9401 Indian Head Highway #360 Ft. Wash., Md 20744</u>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>			23b. DATE <u>4/13/85</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Suitland P.G. Maryland</u>			
24. FUNERAL DIRECTOR NAME <u>George P. Kalas Funeral Home</u>						25. DATE REC'D. BY REGISTRAR <u>APR 12 1985</u>				
25. REGISTRAR'S SIGNATURE <u>Gula Davidson-Randall</u>										

MEDICAL CERTIFICATION

APR 10 1985

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 1-800-368-5878.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Margaret P. Cullen			2a. DATE OF DEATH MONTH DAY YEAR 4-11-85			2b. HOUR P M 1:35 P M					
3. SEX F		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 5 2 1897		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS		IF UNDER 1 YEAR MONTHS DAYS 10		IF UNDER 24 HRS HOURS MIN. 10	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington DC			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Prince George MD.		
10. CITY OR TOWN OF DEATH Mitchellville			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Villa Rosa Nursing Home			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary			12b. KIND OF BUSINESS OR INDUSTRY U.S. Bureau		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE MD			13b. COUNTY PG		13c. CITY OR TOWN Forestville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 7125 Donnell Pl. 20747		

14. FATHER'S NAME FIRST MIDDLE LAST John Thomas Cullen			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie E Peyton					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. 577-60-5456			17. INFORMANT Rev. A. Dal Balcon - 3800 Lottsford Vista Rd. Mitchellville, MD		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarct.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	DUE TO, OR AS A CONSEQUENCE OF (b) Coronary clonus.		
	DUE TO, OR AS A CONSEQUENCE OF (c) Cerebro-vascular		
	PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)		

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 6:29 19 79 4-11		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)			
21d. INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 6-29 19 79 to 4-11 19 85 , that (I) (we) lost saw the deceased alive on 4-11 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Ciro A. Montano		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4-11-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CIRO A. MONTANO MD		22e. ADDRESS 3308 Dodge PK Rd - Landover MD					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 15 April 1985		23c. NAME OF CEMETERY OR CREMATORY Mt OLIVET CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE Washington DC			
24. FUNERAL DIRECTOR NAME Robert E Wilhelm Funeral Home				ADDRESS Suitland, Md		25a. DATE REC'D. BY REGISTRAR APR 22 1985		25b. REGISTRAR'S SIGNATURE L. L. Rindell	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

REPORT ANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certificate must be classified as such.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Mary R. Cundiff			2a. DATE OF DEATH MONTH DAY YEAR April 6, 1985			2b. HOUR 9:15A M					
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR January 19, 1923		6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges County MD.					
10. CITY OR TOWN OF DEATH Laurel		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greater Laurel Beltsville Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Waitress		12b. KIND OF BUSINESS OR INDUSTRY Restaurant			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY P.G. Co.		13c. CITY OR TOWN Laurel		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 404 Marshall Ct. / 20707		
14. FATHER'S NAME FIRST MIDDLE LAST Joseph - Percy				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maude - Corcoran							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) None		17. INFORMANT John E. Cundiff (Husband) Same as # 13.						

18. CAUSE OF DEATH (Enter only one cause per line, for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Acute Respiratory & cardiac arrest

DUE TO, OR AS A CONSEQUENCE OF

(b)

Acute myocardial infarction

DUE TO, OR AS A CONSEQUENCE OF

(c)

Acute severe pulmonary edema

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

acute spastic convulsive seizure

19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTED TO CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR AM/PM DAY YEAR — PM 1985		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) N/A			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) N/A		21f. LOCATION STREET CITY OR TOWN COUNTY STATE N/A			
22a. I certify that (I) (this hospital) attended the deceased from 04-06-1985 to 04-06-1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE J. JON MARSHAWO				DEGREE M.D.		22c. DATE SIGNED 4-07-85	
23a. PHYSICIAN'S NAME (TYPE OR PRINT) J. JON MARSHAWO				23b. ADDRESS 4455 Ft. Meade Rd Suite 209 Laurel MD			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE April/8/85		23c. NAME OF CEMETERY OR CREMATORY Chambers Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Riverdale, P.G. Co., Maryland	
24. FUNERAL DIRECTOR NAME Chambers Funeral Home				ADDRESS Riverdale, Maryland		25a. DATE REC'D. BY REGISTRAR APR 10 1985	
				25b. REGISTRAR'S SIGNATURE			



116123

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 1 2 2 3 0	
1. DECEASED NAME (TYPE OR PRINT) Towanda Cunningham						2a. DATE KNOWN OF DEATH 4-13 19 85		2b. HOUR 3:55 p.			
3. SEX Female		4. RACE Black		5. DATE OF BIRTH July 8, 1957		6. AGE (IN YEARS) 27 YRS.		7. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County, MD.					
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince George's General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE MD		13b. COUNTY Prince Georges		13c. CITY OR TOWN Landover		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 7838 Sheriff Road #B 20785			
14. FATHER'S NAME FIRST James MIDDLE LAST Fisher				15. MOTHER'S MAIDEN NAME FIRST Joyce MIDDLE LAST Williams							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 579-76-1294		17. INFORMANT James Fisher ADDRESS 5936 East Capitol St. NE Washington, D.C. 20019					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Blunt Trauma to Abdomen with Complications DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 2-2 1985		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject was assaulted					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home		21f. LOCATION STREET 7838 Sheriff Road, Landover, Prince George's Co., Md. CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE <i>Dennis F. Smyth</i>				TITLE (SPECIFY) Assistant M.D. MEDICAL EXAMINER				DATE SIGNED 4-14-85			
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D.				ADDRESS 111 Penn St., Balto., Md. 21201							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/20/85		23c. NAME OF CEMETERY OR CREMATORY Harmony Memorial Park		23d. LOCATION CITY OR TOWN Landover COUNTY Prince George's STATE MD					
24. FUNERAL DIRECTOR NAME ROLLINS FUNERAL HOME, INC.				ADDRESS 4339 HUNT PLACE, N.E. WASHINGTON, D.C. 20019		25a. DATE REC'D. BY REGISTRAR Apr 19 1985		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

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ROLLINS FUNERAL HOME, INC.
4330 HUNT PLACE, N.E.
WASHINGTON, D.C. 20010

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LYDA ERNESTINE CURTIS			2a. DATE OF DEATH MONTH DAY YEAR April 20 1985		2b. HOUR 8:50 PM	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR April 11, 1911		
6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, DC		8. CITIZEN OF WHAT COUNTRY? USA		
9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD.		10. CITY OR TOWN OF DEATH Brandywine		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 7911 Cedarville Rd.		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home Maker		13a. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
13b. STREET ADDRESS / ZIP CODE 7911 Cedarville Rd./20613		14. FATHER'S NAME FIRST MIDDLE LAST Clarence Hatton		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marion Phumphy		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 216-70-9924		17. INFORMANT ADDRESS George T. Curtis III 7913 Cedarville Brandywine, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiorespiratory Failure DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Cardiovascular Disease Yes! DUE TO, OR AS A CONSEQUENCE OF (c) Cancer of Colon 8 mo APPROXIMATELY BETWEEN ONSET AND DEATH 12 hrs						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a Diabetes Mellitus						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (the hospital) attended the deceased from 9/23/69 , 19 85 , to April 20 19 85 , that (I) (we) last saw the deceased alive on April 20 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (didn't) view the body after death.						
22b. SIGNATURE Thomas L. Fieldson M.D. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 4/20/85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Thomas L. Fieldson, M.D.				22e. ADDRESS Brandywine, Maryland 20613		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/23/85		23c. NAME OF CEMETERY OR CREMATORY Immanuel U.M. Cem.		
23d. LOCATION CITY OR TOWN COUNTY STATE Baden, Prince Geo. Md		24. FUNERAL DIRECTOR NAME Huntt Funeral Home ADDRESS P. O. Box 156 Waldorf, Md. 20601				
25a. DATE REC'D. BY REGISTRAR APR 23 1985		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall				

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

149051

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201
Medical Examiner notified and released
for Doctors' signature
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST GENE Marie DALEY				2a. DATE OF DEATH MONTH DAY YEAR APRIL 26, 1985	
3. SEX FEMALE		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 18 1923	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Florida		7b. CITIZEN OF WHAT COUNTRY? United States		6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS.	
10. CITY OR TOWN OF DEATH ANDREWS AFB, MD.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Malcolm Grow Medical Center		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY own home		13a. STREET ADDRESS / ZIP CODE 4109 Skyline Drive 20746	
13a. STATE Maryland		13b. COUNTY PG		13c. CITY OR TOWN Suitland	
14. FATHER'S NAME FIRST MIDDLE LAST Unobtainable		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unobtainable		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	
16b. SOCIAL SECURITY NO. 578-28-1351		17. INFORMANT JOHN P. DALEY		ADDRESS 2031 Brooks Drive Forestville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (c) Myocardial Infarction PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 26 Apr 1985 to 26 Apr 1985 , that (I) (we) last saw the deceased alive on 26 Apr 1985 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Carol A. Rupe		DEGREE ATTENDING PHYSICIAN MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 26 Apr 85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CAROL A. RUPE		22e. ADDRESS MALCOLM GROW MED CEN ANDREWS AFB MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 30 Apr 85		23c. NAME OF CEMETERY OR CREMATORY Arlington National	
23d. LOCATION CITY OR TOWN COUNTY STATE Arlington VA		23e. NAME OF FUNERAL HOME Suitland, Md.		23f. DATE REC'D. BY REGISTRAR MAY 06 1985	
24. FUNERAL DIRECTOR Robert E Wilhelm Funeral Home					

134024

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Adell T DAVIS			2a. DATE OF DEATH MONTH DAY YEAR 4-27-85		2b. HOUR 4 12 AM
3. SEX Female	4. RACE BLACK	5. DATE OF BIRTH MONTH DAY YEAR 11-7-18	6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S MD.		
10. CITY OR TOWN OF DEATH SILVER SPRING	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY GOVT.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE D.C.		13b. CITY OR TOWN WASHINGTON	13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 611 EDGEWOOD ST., N.E. 99994	
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM THOMPSON		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST GEORGIE POPE			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 238-16-8331	17. INFORMANT ADDRESS 2915 WOODLAND AVE. ESSIE T. JOYNER, NORFOLK, VA.		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

Acute Heart Failure

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last

(b) Ischemic Myocardopathy

DUE TO, OR AS A CONSEQUENCE OF

(c) Hypertension

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (a) (this hospital) attended the deceased from 4/23/85 19 to 4/27/85 19 that (b) (we) last saw the deceased alive on 4-26-85 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (c) (we) (did) (did not) view the body after death.			
22b. PHYSICIAN'S NAME (TYPE OR PRINT) Charles L. Franklin Jr		DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 4-27-85

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE MAY 1, 1985	23c. NAME OF CEMETERY OR CREMATORY CALVARY CEMETERY	23d. LOCATION CITY OR TOWN COUNTY STATE NORFOLK VA
24. FUNERAL DIRECTOR NAME J.B. JENKINS FUNERAL HOME,		25a. DATE REC'D. BY REGISTRAR MAY 2 1985	REGISTRAR'S SIGNATURE Julia Davidson-Randall

130461



120052

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT)			2a DATE OF DEATH			2b HOUR			
FIRST MIDDLE LAST LUCY MARIE DAVIS			MONTH DAY YEAR April 22, 1985			10:10 a.m.			
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS	
Female		Caucasian		MONTH DAY YEAR Nov. 22, 1920		64 YRS			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH			
Maryland		USA				Prince George's Co. MD.			
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY	
Clinton		Southern Maryland Hospital				Housekeeper		Motel	
13a STATE			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		
MD			Charles		Waldorf		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14 FATHER'S NAME FIRST MIDDLE LAST					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST				
John Woodly Morgan					Mary Myrtle Russell				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b SOCIAL SECURITY NO.		17 INFORMANT		
No					579-30-8161		sister		
					Mabel Lewellen Trl. Prk., Waldorf, MD				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 min</u>	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Cardiovascular Disease</u>								Yrs	
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Pneumonia</u>								14 days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Diabetes, Myocardial Infarct</u>									
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (has <u>has not</u>) attended the deceased from <u>Jan</u> , 19 <u>85</u> , to <u>April 22</u> , 19 <u>85</u> , that (I) (was <u>was not</u>) saw the deceased alive on <u>April 22</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (<u>did not</u>) view the body after death.									
22b SIGNATURE <u>Thomas L. Fieldson</u>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED <u>4/22/85</u>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Thomas L. Fieldson, M. D.						22e ADDRESS Brandywine, Maryland 20613			
23a BURIAL, CREMATION, REMOVAL (SPECIFY)			23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION CITY OR TOWN COUNTY STATE		
Burial			4/24/85		St. Joseph's Cem.		Morganza, St. Mary's, MD		
24. FUNERAL DIRECTOR NAME					25. DATE REC'D. BY REGISTRAR				
Huntt Funeral Home, Waldorf, MD 20601					APR 24 1985				
					25b REGISTRAR'S SIGNATURE <u>John Fieldson</u>				

SECRET

TO: [illegible]

FROM: [illegible]

SUBJECT: [illegible]

DATE: [illegible]

CLASSIFICATION: [illegible]

REMARKS: [illegible]

APPROVAL: [illegible]

SIGNATURE: [illegible]

OFFICE: [illegible]

LOCATION: [illegible]

STATUS: [illegible]

REMARKS: [illegible]

APPROVAL: [illegible]

SIGNATURE: [illegible]

OFFICE: [illegible]

LOCATION: [illegible]

STATUS: [illegible]

REMARKS: [illegible]

TO: [illegible]

FROM: [illegible]

SUBJECT: [illegible]

DATE: [illegible]

CLASSIFICATION: [illegible]

REMARKS: [illegible]

APPROVAL: [illegible]

SIGNATURE: [illegible]

OFFICE: [illegible]

LOCATION: [illegible]

STATUS: [illegible]

REMARKS: [illegible]

APPROVAL: [illegible]

SIGNATURE: [illegible]

OFFICE: [illegible]

LOCATION: [illegible]

STATUS: [illegible]

REMARKS: [illegible]



RECEIVED

101037

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD., 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1 2 2 3 5

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE KNOWN OF DEATH		<input checked="" type="checkbox"/> MONTH	DAY	YEAR	2b. HOUR
Susan		Allegre		Davis	4		1	1985	5:55	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)	IF UNDER 1 YR.		7c. DATE PRONOUNCED DEAD		2d. HOUR	
Female	Caucasian	March 22 1895		90 YRS.			4 1 1985		5:55	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
North Carolina		U.S.A.				Prince George's MD.				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Temple Hills		5939 Fisher Road Apt. 102				Housewife		N/A		
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS		
Maryland		Prince George's		Temple Hills		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		5939 Fisher Rd. #102 20748		
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME								
FIRST MIDDLE LAST		FIRST MIDDLE LAST								
William B. Wingate		Bessie Noble								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS						
No		579-01-7058		Betty Lou Shumate 5604 Auth Rd. Suitland Maryland						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										
PART I DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u>										
DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.										
(b) _____										
DUE TO, OR AS A CONSEQUENCE OF										
(c) _____										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?		
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
		P.M. 19								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> .										
ACTUAL SIGNATURE		TITLE (SPECIFY)				MEDICAL EXAMINER		DATE SIGNED		
Augusto P. Rodriguez		Deputy						4-1-85		
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS								
Augusto P. Rodriguez, M.D.		5009 Rayburn Ct., Temple Hills, Md								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY	STATE	
Burial		4/5/85		Ft. Lincoln Cemetery		Brentwood		P.G.	Maryland	
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
George P. Kalas Funeral Home 6160 Oxon Hill Rd. Oxon Hill, Md.				APR 8 1985						

07/84
25M

BP

DHMH - 17
(VR A15 ME (5))

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM W-3. BRITAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

101037

Algeria

General Secretary of the U.S.S.R.

U.S.S.R.

U.S.S.R.

Algeria

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U.S.S.R.

U.S.S.R.

U.S.S.R.

102116

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH YOUR FILES AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/B4
25MBP _____
DHMH - 17
(VR A15 ME (5))1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 2 2 3 6

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Joyce M Deasy			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR HOUR 4-3 1985	
1. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR May 6, 1937	6. AGE (IN YEARS) LAST BIRTHDAY YRS. 47	IF UNDER 1 YR. MONTHS DAYS HOURS MIN. 47 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Michigan	7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County
10. CITY OR TOWN OF DEATH Bowie	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2712 Bartlett Lane		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary	12b. KIND OF BUSINESS OR INDUSTRY Engineering
13a. STATE Maryland	13b. COUNTY Prince George's	13c. CITY OR TOWN Bowie	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 2712 Bartlett Lane 20715
14. FATHER'S NAME FIRST MIDDLE LAST Harry McAllister		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Frances Duncan		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 192-28-3700		17. INFORMANT James G. Deasy ADDRESS 2712 Bartlett Lane Bowie, Maryland 20715
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the lung DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .				
ACTUAL SIGNATURE Augusto P. Rodriguez		TITLE (SPECIFY) Deputy		MEDICAL EXAMINER DATE SIGNED 4-4-85
EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez, M.D.		ADDRESS 5009 Rayburn Ct., Temple Hills, Md		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE April 8, 1985	23c. NAME OF CEMETERY OR CREMATORY Sacred Heart Church Cem. Bowie, Prince George's, MD	
24. FUNERAL DIRECTOR NAME Beall Funeral Home		ADDRESS 16000 Annapolis Road Bowie, MD 20715-3043		25a. DATE REC'D. BY REGISTRAR APR 9 1985
25b. REGISTRAR'S SIGNATURE [Signature]				

102116

Female Caucasian May 9, 1937 #7

Prince George's County

Michigan

Engineering

Secretary

James

Bowie

2112 Bartlett Lane 20112

Prince George's

Maryland

Finance

James

McAllister

Henry

2112 Bartlett Lane
Bowie, Maryland 20112

James G. Henry

102-22-1700

NO

Sealed Henry March 2011, Prince George's, MD

10000 Annapolis Road
Bowie, MD 20112-3043

Local 10000

Local

120027

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Alberta A Demchak			2a. DATE OF DEATH MONTH DAY YEAR 04 15 85 2b. HOUR 10:20 PM		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR April 24, 1927	
6. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S.C.		7b. CITIZEN OF WHAT COUNTRY? USA		6. AGE (IN YEARS LAST BIRTHDAY) 57 YRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S.C.		7b. CITIZEN OF WHAT COUNTRY? USA		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S MD.	
8. CITY OR TOWN OF DEATH Clinton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Md Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary	
9. STATE Maryland		13c. CITY OR TOWN Waldorf		13b. STREET ADDRESS / ZIP CODE 246-7 Westwood Drive 20601	
10. FATHER'S NAME FIRST MIDDLE LAST Willie Drose		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hattie Belle Bodiford		12b. KIND OF BUSINESS OR INDUSTRY Elec. Union	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 578-30-6624		17. INFORMANT ADDRESS Joyce Jones same as #13	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIORESPIRATORY Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) CARCINOMA middle 1/3 Esophagus DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 17 months
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 85		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 4/15 , 19 85 to 4/15 , 19 85 , that (I) (we) last saw the deceased alive on 4/15 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE B. Shauer				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/16/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) B. SHAUER M.D.				22e. ADDRESS 1701 OLD BRANCH AVE. CLINTON MD			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/18/85		23c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Clinton PG MD	
24. FUNERAL DIRECTOR NAME Robert E Wilhelm Fun. Home				25. DATE FILED BY REGISTRAR APR 22 1985			
ADDRESS 4308 Suitland Rd Suitland MD				26. REGISTRAR'S SIGNATURE [Signature]			

75-1052



EX-1052

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 1 2 2 3 8

1- FOR
STATE
REGISTRAR

HERMAN F. DENNIS

REG. NO.

1 DECEASED NAME
(TYPE OR PRINT)

HERMAN F DENNIS

2a DATE OF DEATH

04 16 85

2b HOUR

3:05AM

3 SEX

MALE

4 RACE

WHITE

5. DATE OF BIRTH

APRIL 1, 1913

6 AGE (IN YEARS LAST BIRTHDAY)

72

YRS.

IF UNDER 1 YEAR

MONTHS DAYS

IF UNDER 24 HRS

HOURS MIN.

7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)

GEORGIA

7b CITIZEN OF WHAT COUNTRY?

U.S.A.

8

MARRIED ☒ NEVER MARRIED ☐
WIDOWED ☐ DIVORCED ☐

9 BALTIMORE CITY OR COUNTY OF DEATH

PRINCE GEORGE'S MD.

10 CITY OR TOWN OF DEATH

CLINTON

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SIC FACILITY, GIVE STREET ADDRESS)

Southern Md. Hospital

12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)

Retired Salesman Meat Co. Evens &

12b KIND OF BUSINESS OR INDUSTRY

Meat Co. Evens &

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Maryland

13b. COUNTY

P.G.

13c. CITY OR TOWN

Camp Springs

13d. INSIDE CITY LIMITS?

YES ☐ NO ☒

13e. STREET ADDRESS / ZIP CODE

5106 Sharon Road

VanCleeef

20748

14 FATHER'S NAME

Ferdinand S. Dennis

15 MOTHER'S MAIDEN NAME

Adele Caver

16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)

Yes

16b SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)

WWII

17 INFORMANT

578-05-8551

ADDRESS

Virginia M. Dennis

Same As #13

18 CAUSE OF DEATH (Enter only one cause per line or row, do not re-use)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Respiratory Insufficiency

DUE TO OR AS A CONSEQUENCE OF

Lung Carcinoma

DUE TO OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

19a DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a AUTOPSY?

YES ☐ NO ☒20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES ☐ NO ☐21a ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)

21d INJURY OCCURRED

21e PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f LOCATION

CITY OR TOWN

COUNTY

STATE

22a I certify that (I) (this hospital) attended the deceased from

4/10

19 85

to 4/16

19 85

saw the deceased alive on 4/15 19 85 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.

22b SIGNATURE

DEGREE

ATTENDING
PHYSICIANMEDICAL
DIRECTORSTAFF
PHYSICIAN

22c DATE SIGNED

4/16/85

22d PHYSICIAN'S NAME (TYPE OR PRINT)

S. Jose F. M.D.

22e ADDRESS

7501 Surrette Rd. Clinton, Md.

23a BURIAL, CREMATION, REMOVAL
(SPECIFY)

Burial

23b. DATE

4/18/85

23c. NAME OF CEMETERY OR CREMATORY

Maryland Veterans Cemetery Cheltenham Maryland P.G.

23d. LOCATION

CITY OR TOWN

COUNTY

STATE

24 FUNERAL DIRECTOR

Lee Funeral Home, Inc.

25a DATE RECEIVED BY REGISTRAR

APR 16 1985

25b REGISTRAR'S SIGNATURE

6633 Old Alexander Ferry Road Clinton, Maryland 20735

108123

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

A3

107110

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 2 2 3 9

FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Manish Kumar C. Desai			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 4-10 19 85		2b. HOUR M 5:36
3. SEX Male	4. RACE Indian	5. DATE OF BIRTH MONTH DAY YEAR 10 23 62	6. AGE (IN YEARS) (LAST BIRTHDAY) 22 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 4-11 19 85
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) India		7b. CITIZEN OF WHAT COUNTRY? India		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH Beltsville		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) rear of 6100 Avondale Road		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Unemployed	
13a. STATE Md.		13b. CITY OR TOWN Prince George Beltsville		13c. STREET ADDRESS 11324 Evans Trail 20705	
14. FATHER'S NAME FIRST MIDDLE LAST Chandrakant H. Desai			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Kokila Parekh		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220 - 92 - 2098		17. INFORMANT ADDRESS Arvind H. Desai 12233 Guinevere Rd. Glenndale, Md. 20769	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypothermia DUE TO, OR AS A CONSEQUENCE OF (b) Exposure DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 Inanition					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 4-10 1985		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) exposure to cold	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) wooded area		21f. LOCATION STREET CITY OR TOWN COUNTY STATE rear of 6100 Avondale Rd., Beltsville, Prince George's Co., Md.	
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion					
ACTUAL SIGNATURE <i>Dennis F. Smyth</i>		TITLE (SPECIFY) Assistant		DATE SIGNED 4-12-85	
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D.		ADDRESS 111 Penn St., Balto., Md. 21201			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 4/13/85		23c. NAME OF CEMETERY OR CREMATORY Loudon Park	
24. FUNERAL DIRECTOR NAME Gary L. Kaufman Funeral Home		ADDRESS 5695 Main Street Elkridge, Maryland 21227		25a. DATE RECEIVED BY REGISTRAR APR 15 1985	
25b. REGISTRAR'S SIGNATURE					

10710

24

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Blanche De Vries			2a. DATE OF DEATH MONTH DAY YEAR 4-20-1985			2b. HOUR 8:20 A M				
3. SEX F		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 4 - 24 - 88		6. AGE (IN YEARS LAST BIRTHDAY) 96 YRS.		7. UNDER 1 YEAR MONTHS DAYS 11		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N. Y. C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George MD.				
10. CITY OR TOWN OF DEATH Mitchellville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Villa Rosa Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) San. Engineer		12b. KIND OF BUSINESS OR INDUSTRY Cesspool Ind.		
13a. STATE NY			13b. CITY OR TOWN Kings Brooklyn		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS / ZIP CODE Flatbush-2107 Ditmas Ave. 99999			
14. FATHER'S NAME FIRST MIDDLE LAST George De Vries			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah Yarwood			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no				
16a. SOCIAL SECURITY NO. 059-07-7833			17. INFORMANT Rev. A. Dal Balcon - 3800 Lottsford Vista Rd. Mitchellville, MD							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction.</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronary artery aurt.</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>3-13</u> , 19 <u>85</u> , to <u>4-20</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>4-12</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>[Signature]</u>			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 4-20/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Piero A. Montanez MD			22e. ADDRESS 3304 Dodge PK Rd - Landover							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 4/23/85		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Bronx N.Y.			
24. FUNERAL DIRECTOR Hines/Rinaldi 11800 New Hamp Ave. S.S. Md			25a. DATE REC'D. BY REGISTRAR APR 22 1985			25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>				

MEDICAL CERTIFICATION



120016

FOR
STATE
REGISTRARMedical Examiner Notified
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 2 2 4 1

1 DECEASED NAME (TYPE OR PRINT)			2a DATE OF DEATH			2b HOUR		
Fortunato Di Domenico			April 20, 1985			9:00 A M		
3 SEX	4 RACE	5. DATE OF BIRTH	6 AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		
Male	Caucasian	September 2, 1920	64			MONTHS DAYS HOURS MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH					
Italy	Italy		Prince George's County, MD.					
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY		
Camp Springs	5808 Middleton Court		Tile Setter			Ceramics		
13a STATE			13b COUNTY			13c CITY OR TOWN		
Maryland			Prince George's			Camp Springs		
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME			13d INSIDE CITY LIMITS?		
Antonio Di Domenico			Emelia Giacomelli			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b SOCIAL SECURITY NO.			17 INFORMANT ADDRESS		
No			N/A			550-50-1719 Rosanna Di Domenico - Same As #13 A-E		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of lung</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>19 mos.</u>								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a								
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART I OR PART 2)		
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NO: WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE		
22a I certify that (I) (this hospital) attended the deceased from <u>Sept 19 83</u> to <u>April 20 85</u> that (I) (we) last saw the deceased alive on <u>April 11 19 85</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			22b SIGNATURE <u>J. Sanford Young</u> DEGREE <u>M.D.</u>			22c DATE SIGNED <u>04/20/85</u>		
22e PHYSICIAN'S NAME (TYPE OR PRINT) <u>J. Sanford Young, M. D.</u>			22d ADDRESS <u>11701 Livingston Road Fort Washington, Maryland</u>					
23a BURIAL, CREMATION, REMOVAL (SPECIFY)			23b DATE			23c NAME OF CEMETERY OR CREMATORY		
Burial			April 22, 1985			Resurrection Cemetery		
24 FUNERAL DIRECTOR NAME			24b ADDRESS			25a DATE REC'D. BY REGISTRAR		
Lee Funeral Home, Inc.			16633 Old Alexander Ferry Road, Clinton, Maryland			APR 25 1985		
25b REGISTRAR'S SIGNATURE			25c REGISTRAR'S SIGNATURE					
			<u>J. Sanford Young</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

20% COLLOIDAL SILICA

WATERMAN



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MAMIE A. DIMES			2a. DATE OF DEATH MONTH DAY YEAR 4 6 85		2b. HOUR 8:45 PM	
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 6 22 01		6. AGE (IN YEARS LAST BIRTHDAY) 83
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland Germantown		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD
10. CITY OR TOWN OF DEATH Riverdale, MD		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Leland Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Cook		12b. KIND OF BUSINESS OR INDUSTRY Univ. of Md.
13a. STATE Maryland		13b. COUNTY Brentwood		13c. STREET ADDRESS / ZIP CODE 4508 Rhode Island Ave. 20722		
14. FATHER'S NAME FIRST MIDDLE LAST Sandy Beckwith			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bertie Talley			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 579-26-2133		17. INFORMANT ADDRESS Mrs. Isabell C. Dimes/daughter/same as 13e		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (b) ATHEROSCLEROSIS DUE TO, OR AS A CONSEQUENCE OF (c) UNKNOWN						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: ORGANIC BRAIN SYNDROME - MULTIPLE CEREBROVASCULAR ACCIDENTS						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (1) (this hospital) attended the deceased from 1 19 80 , to 4/6 19 85 , that (1) (we) last saw the deceased alive on 4/6 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE J. Reinschagen		DEGREE MD		22c. DATE SIGNED 4/6/85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JERREINSHAGEN		22e. ADDRESS 4404 RIVERDALE RD RIVERDALE, MD				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4-11-85		23c. NAME OF CEMETERY OR CREMATORY Md. National Mem. Pk.		
23d. LOCATION CITY OR TOWN COUNTY STATE Laurel, Md.						
24. FUNERAL DIRECTOR NAME ADDRESS John T. Rhines Co., 3015 12th St. N.E., D.C. 20017		25a. DATE REC'D. BY REGISTRAR APR 16 1985		25b. REGISTRAR'S SIGNATURE G. B. Borden		

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copiers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

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Prince Georges

Leiford Memorial Hospital

100-111

120071

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 2 2 4 3

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Angelo DiNapoli			2a. DATE OF DEATH MONTH DAY YEAR 4 22 85			2b. HOUR 10:04 AM			
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Jan. 25 1916		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Italy		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George MD.			
10. CITY OR TOWN OF DEATH Clinton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Maryland Hospital Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Barber		12b. KIND OF BUSINESS OR INDUSTRY Barber	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Maryland		13b. COUNTY Prince George		13c. CITY OR TOWN Temple Hills		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 7007 Westchester Drive 20748	
14. FATHER'S NAME FIRST MIDDLE LAST Marco DiNapoli			15. MOTHER'S MAIDEN NAME MIDDLE Maria Papa						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 578-03-4752		17. INFORMANT Antonieta DiNapoli ADDRESS 7007 Westchester Dr. Temple Hills, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO-PULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) CEREBRAL HEMORRHAGE DUE TO, OR AS A CONSEQUENCE OF (c) ALTERATION OF CEREBROVASCULAR								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 DAY 1 DAY 1 YEAR	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (1) the hospital attended the deceased from MARCH 30, 1985 to APRIL 22, 1985 , that (1) the last saw the deceased alive on APRIL 22, 1985 , and that in (my) the opinion death occurred on the date and hour and from the causes stated above, (1) the did not view the body after death.									
22b. SIGNATURE Bruno Kolega			DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 4/22/85			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Bruno Kolega			22e. ADDRESS 4400 Stamp Rd. Marlow Heights, Md.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 4/25/85		23c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Clinton P.G. Maryland		
24. FUNERAL DIRECTOR NAME G.P. Kalas					ADDRESS 6160 Oxon Hill Rd. Oxon Hill, Md.		25a. DATE REC'D. BY REGISTRAR APR 24 1985		
					25b. REGISTRAR'S SIGNATURE [Signature]				

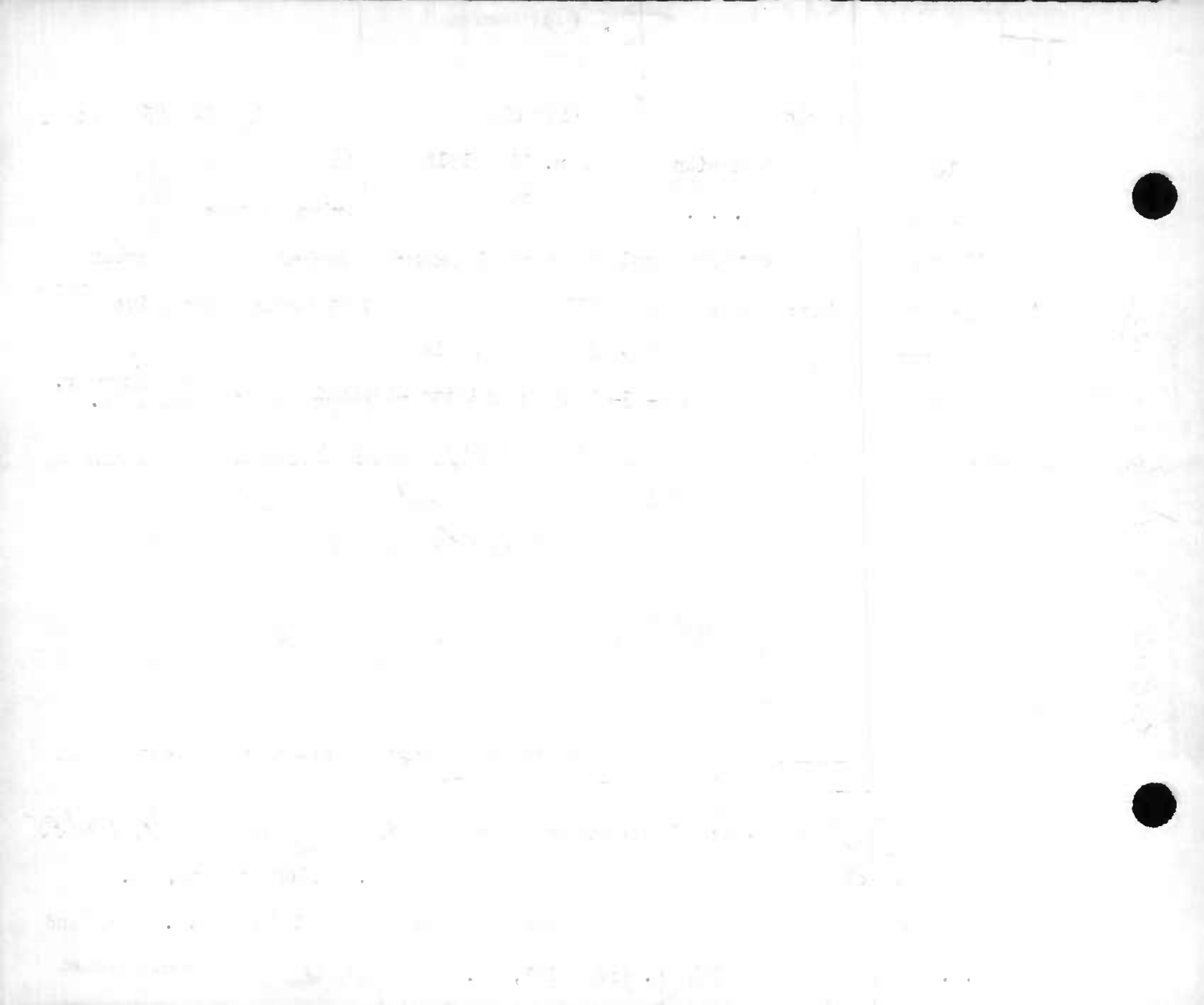
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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and an autopsy required.

Released by *[Signature]*



129004

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Charles E DONALDSON				2a. DATE OF DEATH MONTH DAY YEAR 04 26 85		2b. HOUR 11:20AM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept 22 1948		6. AGE (IN YEARS LAST BIRTHDAY) 36 YES	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington DC		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S MD.	
10. CITY OR TOWN OF DEATH CLINTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN THIS FACILITY, GIVE STREET ADDRESS) Southern Md Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Painter		12b. KIND OF BUSINESS OR INDUSTRY Self Employed	
13a. STATE Maryland				13b. COUNTY Charles		13c. CITY OR TOWN Waldorf	
14. FATHER'S NAME FIRST MIDDLE LAST Lewis M Donaldson				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Vera E. Quigley			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) Viet Nam		17. INFORMANT Nancy M Donaldson		Same as #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiorespiratory accident DUE TO, OR AS A CONSEQUENCE OF (b) 2nd intracerebral hemorrhage Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) acute lymphocytic leukemia							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in item 18, Part 1, or Part 2)			
21d. INJURY OCCURRED AT HOME <input type="checkbox"/> NOT HOME <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (i) (this hospital) attended the deceased from April 26 1985 to April 26 1985 that (i) (we) last saw the deceased alive on April 26 1985 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we (I) did not view the body after death.							
22a. SIGNATURE DJ Naidak		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22b. DATE SIGNED 4/24/85	
22c. PHYSICIAN'S NAME (TYPE OR PRINT) DJ Naidak MD		22d. ADDRESS Clinton, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 29Apr85		23c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Clinton PG Md	
24. FUNERAL DIRECTOR NAME Robert E Wilhelm		ADDRESS Funeral Home		25. DATE REC'D. BY REGISTRAR MAY 06 1985		25b. REGISTRAR'S SIGNATURE Julia Davidson-Hendell	

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trial

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1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

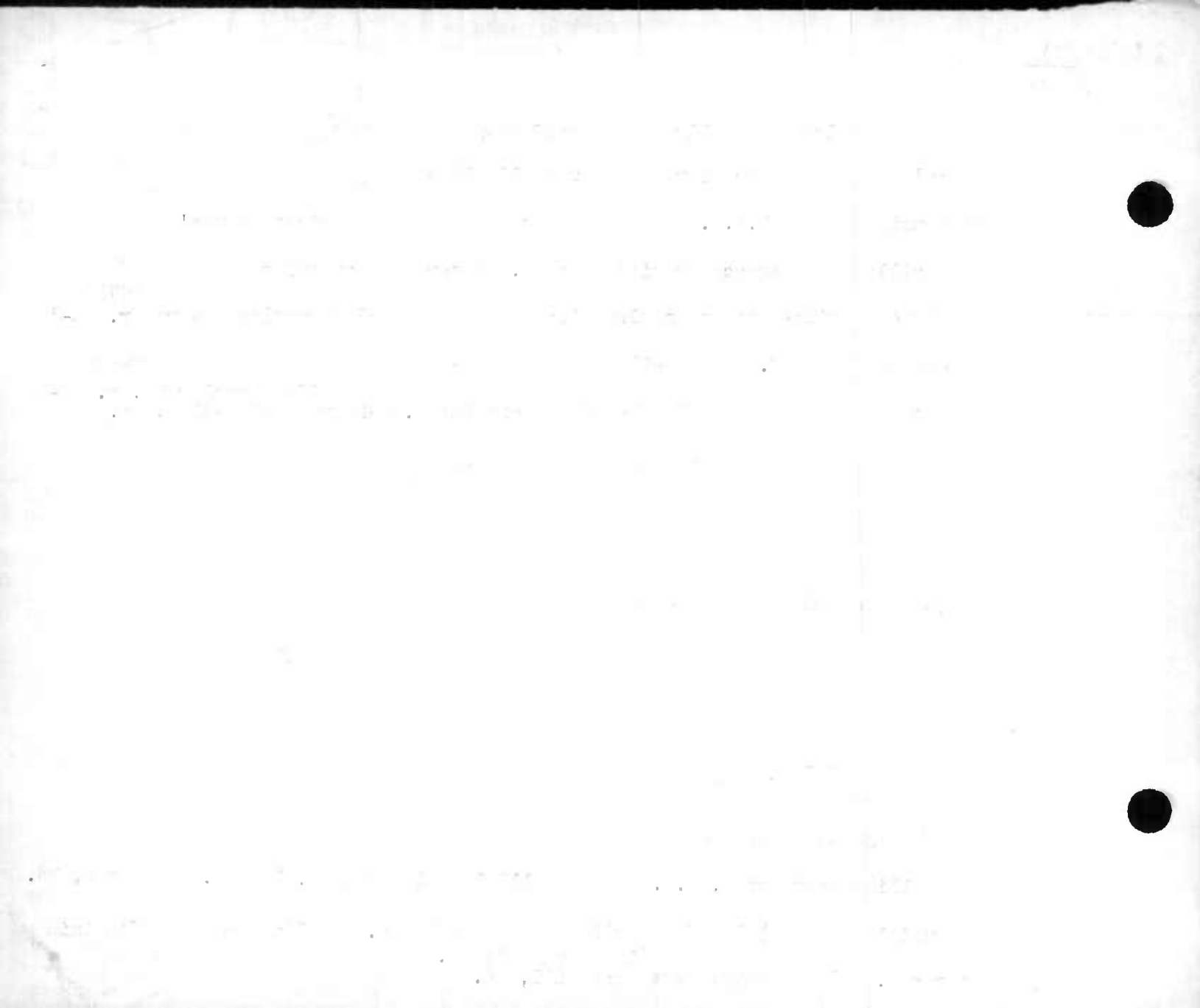
1. DECEASED NAME (TYPE OR PRINT) Helen Kelly Donaldson			2a. DATE OF DEATH MONTH DAY YEAR April 13 1985		2b. HOUR 7:50 AM
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR July 13 1889	6. AGE (IN YEARS LAST BIRTHDAY) 95 YRS.	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Missouri	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.		
10. CITY OR TOWN OF DEATH Forestville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Regency Nursing & Rehab. Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	12b. KIND OF BUSINESS OR INDUSTRY N/A	
13a. STATE Maryland		13b. COUNTY Prince George	13c. CITY OR TOWN Temple Hills	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 3308 Huntley Square Dr. #B-1 20748
14. FATHER'S NAME FIRST MIDDLE LAST Joseph C. Kelly			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Kaufman		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 578-50-6460	17. INFORMANT ADDRESS 3308 Huntley Sq. Dr. #B01 Lorraine D. Wahler Temple Hills, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrhythmia</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>Organic brain syndrome</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>April 25</u> , 19 <u>79</u> , to <u>4-13</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>3-24</u> , 19 <u>85</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.					
22b. SIGNATURE <u>William Kent Furst</u>		DEGREE <u>MD</u>		22c. DATE SIGNED <u>4/13/85</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) William Kent Furst, M.D.		22e. ADDRESS 11701 Livingston Rd. #101 Ft. Washington, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 4/16/85	23c. NAME OF CEMETERY OR CREMATORY Arlington National Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Arlington Virginia	
24. FUNERAL DIRECTOR NAME George P. Kalas Funeral Home Oxon Hill, Md.		25. DATE REC'D. BY REGISTRAR APR 17 1985		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



126157

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 2 2 4 6

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) DELIA Ann Donatelli			2a. DATE OF DEATH MONTH DAY YEAR 4 - 26 - 85		2b. HOUR MIN. 12 34 A	
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR Dec. 5, 1898		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		6 AGE (IN YEARS LAST BIRTHDAY) 86 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
10 CITY OR TOWN OF DEATH HYATTSVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HYATTSVILLE MANOR		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD.		
12 USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.		13b. COUNTY Pr. Geo.		13c. CITY OR TOWN Cheverly		
14 FATHER'S NAME FIRST MIDDLE LAST William Gagne		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Clara Poirior		17b. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 220-48-8623		17. INFORMANT ADDRESS Mildred R. Henry Westbury, N.Y.		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Arteriosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immediate						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from Jan. 15 , 19 79 , to April 26 , 19 85 , that (I) (we) lost saw the deceased alive on March 26 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did not) view the body after death.						
22b. SIGNATURE <i>M. Lenka</i>				22c. DATE SIGNED 4-26-1985		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4-29-1985		23c. NAME OF CEMETERY OR CREMATORY Long Island Nat'l.		
24 FUNERAL DIRECTOR NAME Nalley's F.H. Inc. Mt. Rainier, Md.		23d. LOCATION CITY OR TOWN COUNTY STATE Pinelawn Suffolk N.Y.		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE MAY 01 1985		

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR
1. STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Sudie Burch Donovan			2a. DATE OF DEATH MONTH DAY YEAR 4 24 85		2b. HOUR 6³⁰ AM		
1. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 11- 15 - 11		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Alabama		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD.	
10. CITY OR TOWN OF DEATH Hyattsville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll Manor Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Regist. Nurse		12b. KIND OF BUSINESS OR INDUSTRY Medical	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE N/A		13c. CITY OR TOWN Washington, D.C.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3012 Gainesville St., S. E.	
14. FATHER'S NAME FIRST MIDDLE LAST John F. Burch			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nancy A. Rorex				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 579-44-0399		17. INFORMANT ADDRESS Wash., D.C. 20020 Frances Baker/3012 Gainesville St.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiopulmonary arrest DUE TO, OR AS A CONSEQUENCE OF (b) Alzheimer's disease DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (he (this hospital) attended the deceased from 1/28 , 19 81 , to 4/24 , 19 85 , that (I (we) last saw the deceased alive on 4/23 , 19 85 , and that in (my (our) opinion death occurred on the date and hour and from the causes stated above, (I (we) (did) (did not) view the body after death.							
22b. SIGNATURE David C. Lanier, MD		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/24/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) David C. Lanier, MD		22e. ADDRESS 7676 New Hampshire Ave #210 Laureley Park, MD 20783					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4-26-85		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.	
24. FUNERAL DIRECTOR NAME G.P. Kalas F.H.		ADDRESS 6160 Oxon Hill Rd. Oxon Hill, Md.		25a. DATE REC'D. BY REGISTRAR APR 26 1985		25b. REGISTRAR'S SIGNATURE <i>Wm. Davidson-Randall</i>	

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
FIRST	MIDDLE	LAST	MONTH	DAY	YEAR			
DANIEL E DORSEY			4	30	85			11.55am
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS
Male	Negro	MONTH	DAY	YEAR	88	MONTHS	DAYS	HOURS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		
Washington, D.C.		U.S.A.				PRINCE GEORGES COUNTY MD.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
CLINTON MD		SOUTHERN MARYLAND HOSPITAL				Steam Engineer		None

13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS / ZIP CODE		
Maryland			PG			Oxon Hill			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			2504 Brinkley Rd. 20745		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME											
Frank Dorsey			Maey Elizabeth									Unknown		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			ADDRESS					
No			Unknown			Delfus Dorsey			6405 St. Barnabus Rd. Oxon Hill					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac pulmonary arrest</u>		APPROPRIATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (b) <u>Plasma O Affair</u>			
DUE TO, OR AS A CONSEQUENCE OF underlying cause (c) <u>pos. male pregnancy - metastasis</u>			

PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>Severe weight loss</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1; OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (IF HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (i) (this hospital) attended the deceased from <u>4-7</u> 19 <u>85</u> to <u>4-30</u> 19 <u>85</u> that (ii) (we) last saw the deceased alive on <u>4-30</u> 19 <u>85</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (i) (we) (did) (did not) leave the body after death		22b. SIGNATURE <u>[Signature]</u>		DEGREE M.D.		22c. DATE SIGNED <u>5/1/85</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>STEPHEN ONG, M.D.</u>		22e. ADDRESS <u>6257 Oxon Hill Rd Oxon Hill, Md 20745</u>					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		May 4, 1985		Lincoln Memorial		Suitland, Md.	

24. FUNERAL DIRECTOR'S NAME <u>Robert G. Mason Funeral Home, Inc.</u> <u>1661 Good Hope Rd., S.E. D.C. 20020</u>		25a. DATE REC'D. BY REGISTRAR <u>MAY 13 1985</u>		25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>	
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DIVISION OF VITAL RECORDS, 201 W. PRESTON
BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after pronouncement of death by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked as item 18 shows any injury, an other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked as item 18 shows any injury, an other traumatic event, the medical examiner must be notified at once.

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Washington, D.C. U.S.A.

Steamship Lines

2000 Building Co.

Unknown

Key Building

Frank County

Unknown

Building Lines 2000 Bldg. Co. 2000 Bldg. Co.

Building, No.

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Building, No.

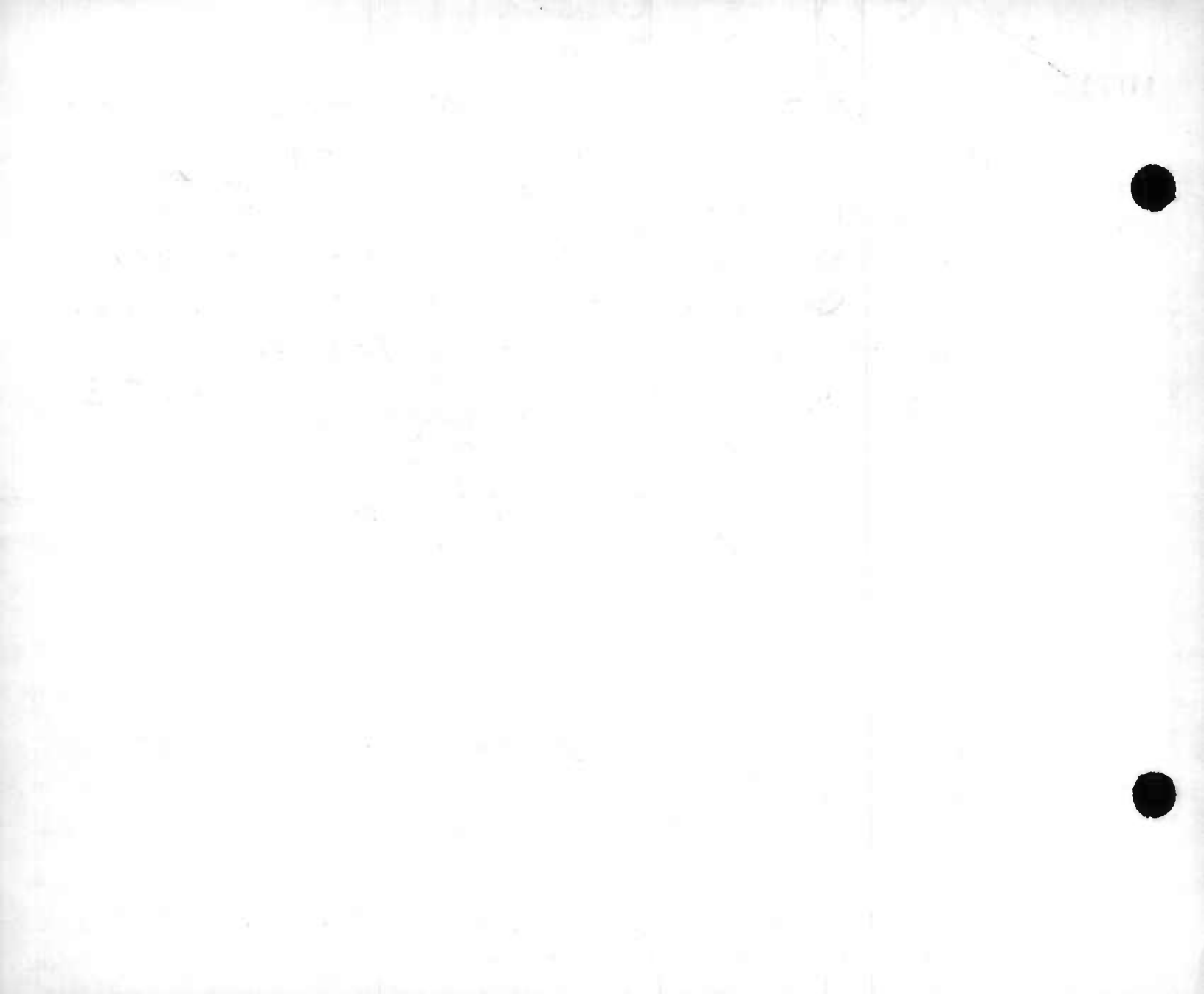
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 2 2 4 9

FOR
1- STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
EVERETT		B		DOWNS JR	APRIL 10, 1985				7:57A M
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS		
Male	White	June 6 1930		54 YRS.	MONTHS		DAYS	HOURS	MIN.
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	10. CITIZEN OF WHAT COUNTRY?	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Maryland	USA	Camp Springs Malcolm Grow Medical Center		Ret US AF		Gov			
13a. CITY OR TOWN OF DEATH	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	11a. STREET ADDRESS / ZIP CODE					
Comp Springs	Calvert	Dunkirk	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	Rt #2 Box 96 20754					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME							
Everett B Downs		Edna NORMAN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
Yes		Korean 220209208		Jean Downs		Same co H13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE <u>cardiopulmonary arrest</u>					CARDIOPULMONARY ARREST				
DUE TO, OR AS A CONSEQUENCE OF <u>MULTIPLE GI BLEEDS</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									
DUE TO, OR AS A CONSEQUENCE OF <u>SEVERE LIVER CIRRHOSIS</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
21g. I certify that (I) (this hospital) attended the deceased from <u>27 March</u> 19 <u>85</u> to <u>10 April</u> 19 <u>85</u> , that (I) (we) lost saw the deceased alive on <u>10 April</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22a. SIGNATURE <u>Russell W. Eggert</u>					DEGREE		22c. DATE SIGNED		
22b. PHYSICIAN'S NAME (TYPE OR PRINT)					ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				
22d. ADDRESS									
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		April 12, 1985		Maryland Veterans		Cheltenham PG MD			
24. FUNERAL DIRECTOR <u>Raboch Funeral Home</u>					DATE REC'D. BY REGISTRAR		75b. REGISTRAR'S SIGNATURE		
Chung, MD					APR 15 1985		<u>Richard Randall</u>		



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1 2 2 5 0

127027

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE KNOWN OF DEATH			2b. HOUR		
FIRST MIDDLE LAST Thomas Eugene Drury			MONTH DAY YEAR 4/ 17/ 19 85			M		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD	2d. HOUR	
Male	White	MONTH DAY YEAR 12 7 1932	52 YRS.	MONTHS DAYS	HOURS MIN.	4/ 17/ 19 85	7:24 P M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		
Washington DC		USA				Prince George's County, MD.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
District Heights		6112 Marlboro Pike			Plumber		SelfEmploy	
13a. STATE		13b. CITY OR TOWN		13c. STREET ADDRESS		13d. INSIDE CITY LIMITS?		
Maryland		PG		Dist. Hgts.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 6301 Foster Street		
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME				
FIRST MIDDLE LAST Thomas Elwood Drury				FIRST MIDDLE LAST Lillian Elizabeth Blake				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT		
						3524 Springdale Ave Jeffrey A Drury Forestville MD		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY:								
IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u>								
DUE TO, OR AS A CONSEQUENCE OF								
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.								
(b) <u>Chronic Alcoholism</u>								
DUE TO, OR AS A CONSEQUENCE OF								
(c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).								
<u>Chronic Alcoholism</u>								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?	
							YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
		HOUR A.M. MONTH DAY YEAR P.M. 19						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION				
				STREET CITY OR TOWN COUNTY STATE				
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural cause <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE		TITLE (SPECIFY)					DATE SIGNED	
		M.D. Assistant					4/18/85	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS						
Gregory R. Kauffman, M.D.		111 Penn St.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		
Burial		4/22/85		Trinity Mem. Gardens		Waldorf Md		
24. FUNERAL DIRECTOR		NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE
Robert E. Wilhelm		Funeral Home		Suitland Maryland		APR 30 1985		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DEATH IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE PLACED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE. DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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NOTICE

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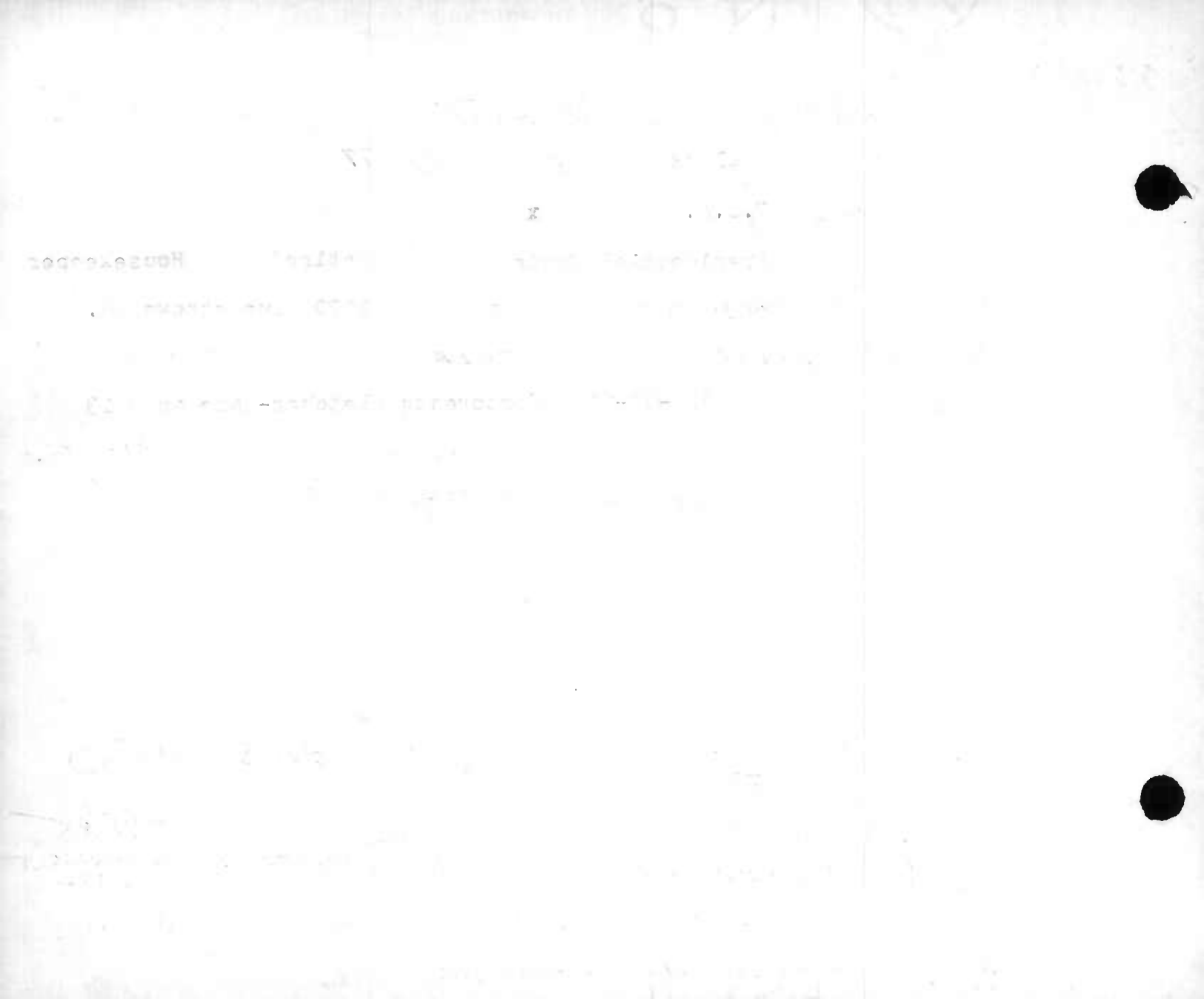
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
FOR 1 - STATE REGISTRAR					REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) <i>Mildred Duckett</i>					2a. DATE OF DEATH MONTH DAY YEAR <i>4-18-1985</i>					2b. HOUR <i>1 45</i> M	
3. SEX <i>Female</i>		4. RACE <i>Black</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>8-31-1907</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>77</i> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		7b. IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Prin. Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> EVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Prince George County</i> MD.					
10. CITY OR TOWN OF DEATH <i>Adelphi</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Presidential Woods</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Retired</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Housekeeper</i>			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE <i>MD</i>		13b. COUNTY <i>Prince George</i>		13c. CITY OR TOWN <i>Bowie</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>12709 Duckettown Rd. 20715</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Robert Hebron</i>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>ELLA BANKS</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>218-20-0309</i>		17. INFORMANT ADDRESS <i>Hortorance Fletcher-Same as # 13</i>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinomatosis</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Months</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) <i>Carcinoma of ovary & uterus</i>										"	
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22. I certify that (I) (this hospital) attended the deceased from <i>4/17/85</i> to <i>4/18/85</i> , that (I) (we) last saw <i>alive</i> on <i>4/17/85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.											
23a. SIGNATURE <i>[Signature]</i>			DEGREE			23b. DATE SIGNED <i>4/17/85</i>					
23c. PHYSICIAN'S NAME (TYPE OR PRINT) <i>SCHESSLER MD</i>			23d. ADDRESS <i>7500 GREENWAY CTR DR GREENBELT MD 20770</i>								
24. BURIAL CREMATION, REMOVAL (SPECIFY)			24b. DATE <i>4/22/85</i>			24c. NAME OF CEMETERY OR CREMATORY <i>MARYLAND NAT'L CEM.</i>			24d. LOCATION CITY OR TOWN COUNTY STATE <i>BELTSVILLE, P. G. Co.</i>		
24. FUNERAL DIRECTOR NAME <i>H.S. WASHINGTON & SONS</i>						24b. ADDRESS <i>4925 BROADWAYS AVE, BALTIMORE</i>					
25a. DATE REC'D. BY REGISTRAR						25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

BP



105040

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

2a DATE OF DEATH MONTH DAY YEAR 2b HOUR
March 31, 1985 12:15 PM1 DECEASED NAME
(TYPE OR PRINT)FIRST MIDDLE LAST
Robert Burns Duncan

3 SEX

Male

4 RACE

Black

5 DATE OF BIRTH

MONTH DAY YEAR
11 5 05

6 AGE (IN YEARS LAST BIRTHDAY)

79

7b UNDER 1 YEAR

MONTHS DAYS

7c UNDER 24 HRS

HOURS MIN

7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Washington, D.C.

7b CITIZEN OF WHAT COUNTRY?

U.S.A.

8 MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

9 BALTIMORE CITY OR COUNTY OF DEATH

Prince George's

MD.

10 CITY OR TOWN OF DEATH

Lanham

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION

(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Doctor's Hospital of Lanham

12a USUAL OCCUPATION

(TYPE OF WORK FOR MOST OF WORKING LIFE)
Carpenter

12b KIND OF BUSINESS OR INDUSTRY

Federal Govt.

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a STATE

MD

13b COUNTY

P.G.

13c CITY OR TOWN

Lanham

13d INSIDE CITY LIMITS?

YES ☒ NO ☐

13e STREET ADDRESS

10004 Buena Vista Avenue 20706

14 FATHER'S NAME

FIRST MIDDLE LAST
Robert A. Duncan

15 MOTHER'S MAIDEN NAME

FIRST MIDDLE LAST
Ella G. Adams

16a WAS DECEASED EVER IN U.S. ARMED FORCES?

(YES, NO OR UNKNOWN)
No

16b SOCIAL SECURITY NO.

(IF YES, GIVE WAR OR DATES)
578-05-5308

17 INFORMANT

Gussie L. Duncan

ADDRESS

10004 Buena Vista Avenue
Lanham, MD 20706

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Uremia

DUE TO OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b)

Renal Failure

DUE TO, OR AS A CONSEQUENCE OF

(c) Cardiovascular Disease

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

1 yr

1 yr

3 yr

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.

Degenerative Joint Disease

19a DATE OF OPERATION

19b CONDITION FOR WHICH OPERATION WAS PERFORMED

20a AUTOPSY?

YES ☐ NO ☐

20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a ACCIDENT WAS UNDERLYING ☐OR CONTRIBUTING ☐ CAUSE OF DEATH

(IF EITHER, NOTIFY MEDICAL EXAMINER)

21b TIME OF INJURY

HOUR A.M. MONTH DAY YEAR

P.M. 19

21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d INJURY OCCURRED

WHILE ☐ HOT WORK ☐AT WORK ☐ AT WORK ☐

21e PLACE OF INJURY

(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a I certify that (I) (this hospital) attended the deceased from 1965 to 3/31 1985, that (I) (we) last

saw the deceased alive on 3/31/85 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated

above, (I) (we) (did) (did not) view the body after death.

22b SIGNATURE

Henry A. Wise Jr.

DEGREE

ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c DATE SIGNED

4/1/85

22d PHYSICIAN'S NAME (TYPE OR PRINT)

Henry A. Wise Jr.

22e ADDRESS

Lanham 4d

23a BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

23b DATE

4/5/85

23c NAME OF CEMETERY OR CREMATORY

Lincoln Memorial

23d LOCATION

CITY OR TOWN

Suitland Prince George's MD

24 FUNERAL DIRECTOR NAME

ROLLINS FUNERAL HOME, INC.

4339 HUNT PLACE, N.E.

WASHINGTON, D.C. 20012

25a DATE REC'D. BY REGISTRAR

25b REGISTRAR'S SIGNATURE

APR 08 1985

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified on page 2.

100030

ROLLING FUNERAL HOME, INC.
4339 HUNT PLACE, N.E.
WASHINGTON, D.C. 20019

127022

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. -

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Roger s C. Dunn			2a. DATE OF DEATH MONTH DAY YEAR April 22, 1985		2b. HOUR 8:52A.M
3. SEX MALE	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR 9-14 82	6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS	7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.Y.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.		
10. CITY OR TOWN OF DEATH LAUREL	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greater Laurel Beltsville Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RESEARCH	12b. KIND OF BUSINESS OR INDUSTRY POLITICAL ANALYST.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD			13b. COUNTY ANNE ARUNDEL	13c. CITY OR TOWN SEVERN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST CLEVELAND A DUNN			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jennifer E. HAINES		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 149-56218	17. INFORMANT ADDRESS Peter H DUNN 1881 LA SALLE PLACE SEVERN, MD		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia.</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>congestive Heart Failure.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>status post Inferior wall myocardial infarction.</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Arteriosclerotic Cardiovascular disease cerebral infarct.</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 WKS.
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>4/7/85</u> 19 <u>85</u> to <u>4/22/85</u> 19 <u>85</u> that (I) (we) lost saw the deceased alive on <u>4/21/85</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) (did not) view the body after death.					
22b. SIGNATURE <u>Abdul Nayeem</u>		DEGREE M.D.		22c. DATE SIGNED 4/22/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ABDUL NAYEEM, M.D.		22e. ADDRESS 3456 Fort Meade Road, LAUREL, M.D. 20707			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 4-23-85		23c. NAME OF CEMETERY OR CREMATORY WESTVIEW MEMORIAL	
23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MD		24. FUNERAL DIRECTOR NAME ADDRESS Peter H. Dunn (SON)			
25a. DATE REC'D BY REGISTRAR APR 30 1985		25b. REGISTRAR'S SIGNATURE <u>James H. Hinkle</u>			

MEDICAL CERTIFICATION

69 84 35 20 2

BP _____

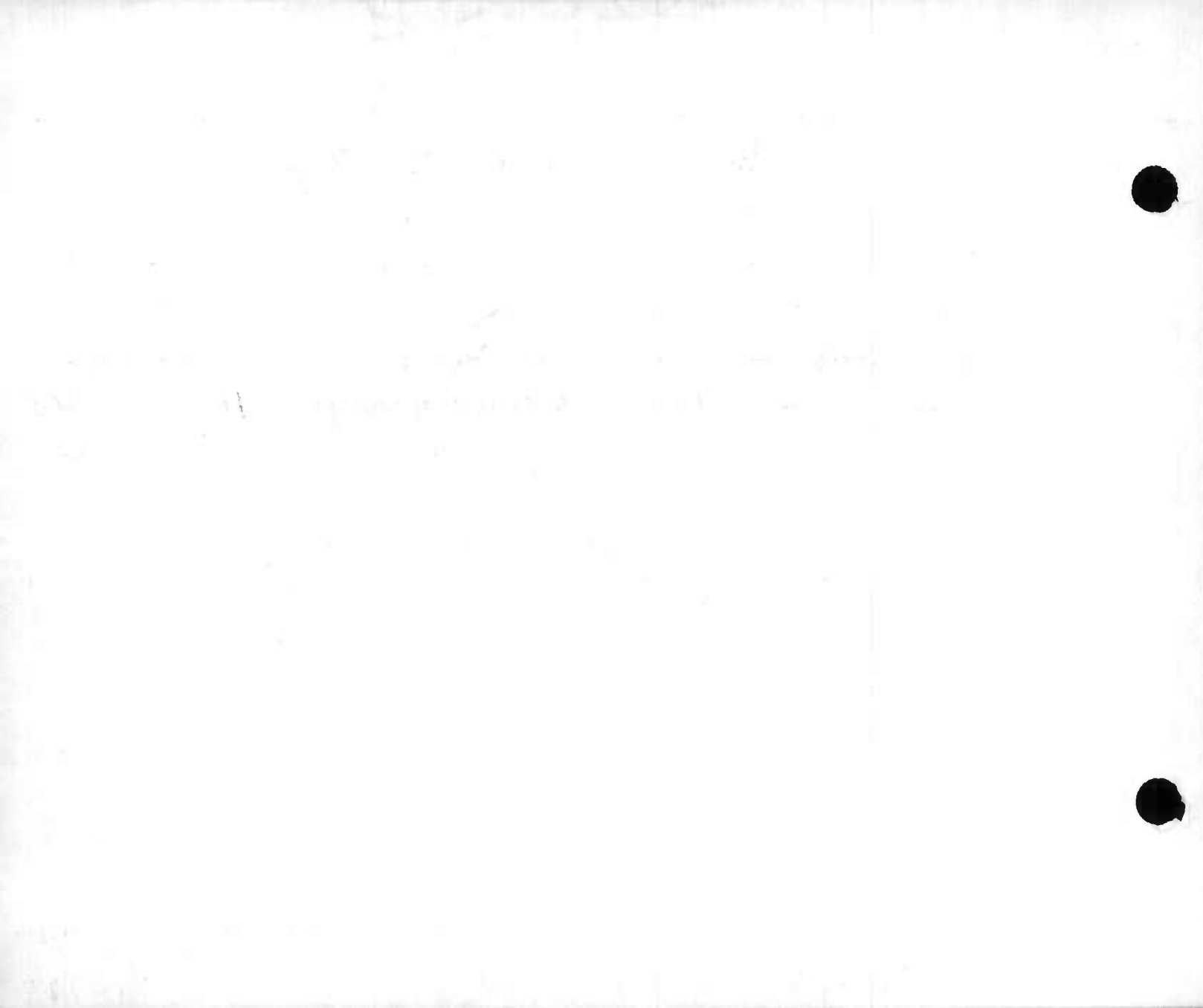
DHMH - 16 50M 4/83
(VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.



106159

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Alfred EDERHEIMER			2a. DATE OF DEATH MONTH DAY YEAR April 7, 1985		2b. HOUR 8:00P M		
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR NOV 19, 1903		6. AGE (IN YEARS LAST BIRTHDAY) YEARS MONTHS DAYS HOURS MIN. 81	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD.	
10. CITY OR TOWN OF DEATH LANHAM		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DOCTORS' HOSPITAL OF P.G. Co.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) NEW YORK LIFE INSURANCE CO.		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MARYLAND		13b. COUNTY PRI. GEORGES		13c. CITY OR TOWN COLLEGE PARK		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST LEOPOLD EDERHEIMER		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST HESSIE K. EDERHEIMER		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 086-05-2615	
17. INFORMANT ADDRESS HESSIE K. EDERHEIMER SAME AS 13 WIFE		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary embolus</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Ischaemic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Congestive Cardiac failure</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Diabetes mellitus Type II</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>10 yrs.</u>			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>3/30/1985</u> to <u>4/7/1985</u> , that (I) (we) last saw the deceased alive on <u>4/7/1985</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Azher Hussain</u>		DEGREE <u>MD</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Azher Hussain M. D.		22e. ADDRESS 4917 Edgewood Rd., College Park, Md. 20740		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 4/11/85	
23c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE BRENTWOOD PRI GEO MD.		24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS		25a. DATE REC'D. BY REGISTRAR APR 11 1985	
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		25c. ADDRESS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901		25d. DATE REC'D. BY REGISTRAR APR 11 1985		25e. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

BP

10013

LIBRARY

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134023

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

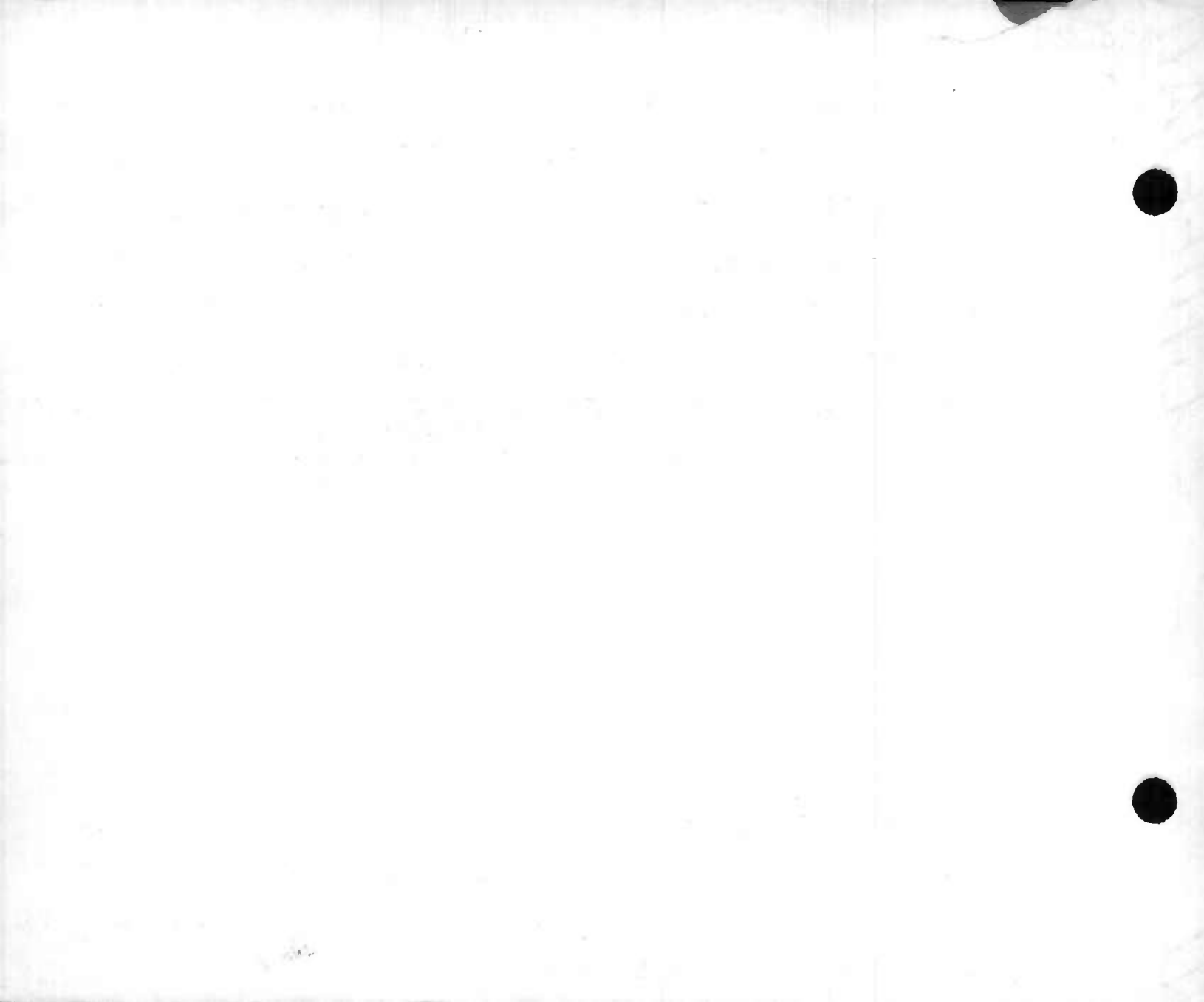
1. DECEASED NAME (TYPE OR PRINT) CARRIE MAE EDWARDS			2a. DATE OF DEATH MONTH DAY YEAR APRIL 25, 1985		2b. HOUR 6:45pM
3. SEX FEMALE	4. RACE BLACK	5. DATE OF BIRTH APRIL 18 1947		6. AGE (IN YEARS LAST BIRTHDAY) 38	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN) SOUTH CAROLINA	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD.	
10. CITY OR TOWN OF DEATH CAMP SPRINGS	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MALCOM GROW HOSP.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) BEAUTICIAN		12b. KIND OF BUSINESS OR INDUSTRY PRIVATE
13a. STATE MARYLAND	13b. COUNTY P.G.	13c. CITY OR TOWN CAMP SPRINGS	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 5607 CAMP SPRINGS AVE 20748	
14. MOTHER'S NAME FIRST MIDDLE LAST ERNEST HACKETT		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CARRIE HACKETT			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. N/A		17. INFORMANT ADDRESS ANDREW EDWARDS 5607 CAMP SPRINGS AVE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) X VIRAL MENINGOENCEPHALITIS DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>R. L. Jenkins</i>		DEGREE		22c. DATE SIGNED 4/25/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RAYMOND ANTHRACITE, M.D.		22e. ADDRESS MALCOM GROW HOSP., CAMP SPRINGS, MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 4/30/85	23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NAT.		23d. LOCATION CITY OR TOWN COUNTY STATE ARLINGTON ARLINGTON VA	
24. FUNERAL DIRECTOR NAME J.B. JENKINS F.H.		ADDRESS 7474 LANDOVER RD		25a. MAY RECORD OF DEATH 8 MAY 1985	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

106080

1. DECEASED NAME (TYPE OR PRINT) HARRY B. ELLIS			2a. DATE OF DEATH MONTH DAY YEAR 04 05 85			2b. HOUR 10 00AM				
3. SEX Male		4. RACE White		5. DATE OF BIRTH DAY MONTH YEAR 10/14/18		6. AGE (IN YEARS LAST BIRTHDAY) 66		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio		9. CITIZEN OF WHAT COUNTRY? U.S.A.		10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD.				
12. CITY OR TOWN OF DEATH CHEVERLY		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PGG HOSPITAL AND MEDICAL CENTER				14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Maintenance		15. KIND OF BUSINESS OR INDUSTRY Post Office		
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 16a. STATE Maryland			16b. COUNTY P.G.		16c. CITY OR TOWN Hyattsville		16d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		16e. STREET ADDRESS / ZIP CODE 4113 Farragut Street 20781	
17. FATHER'S NAME FIRST MIDDLE LAST Joseph Ellis			18. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ina Carlisle							
19. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			20. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) WWII		21. INFORMANT Evelyn M. Ellis		22. ADDRESS 4113 Farragut Street Hyattsville, Md. 20781			
23. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary arrest. DUE TO, OR AS A CONSEQUENCE OF (b) Possible pulmonary embolism not proven DUE TO, OR AS A CONSEQUENCE OF (c) Stable post-carcinoma of prostate resection Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Deafness, illiterates.										
24. DATE OF OPERATION 3/29/85			25. CONDITION FOR WHICH OPERATION WAS PERFORMED Prostate hypertrophy			26. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		27. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
28. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input checked="" type="checkbox"/>			29. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			30. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
31. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			32. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			33. LOCATION STREET CITY OR TOWN COUNTY STATE				
34. I certify that (I) (this hospital) attended the deceased from 3/22 , 19 85 , to 4/5 , 19 85 , that (I) (we) last saw the deceased alive on 9:35 am 4/5 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
35. SIGNATURE F. Sotoudeh						36. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			37. DATE SIGNED	
38. PHYSICIAN'S NAME (TYPE OR PRINT) F. Sotoudeh						39. ADDRESS 7500 Hanover Parkway Greenbelt Md				
40. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			41. DATE 4/9/85		42. NAME OF CEMETERY OR CREMATORY Cheltenham Md. Veterans			43. LOCATION CITY OR TOWN COUNTY STATE Cheltenham P.G. Md.		
44. FUNERAL DIRECTOR Francis Gascch's Sons Funeral Home P.A.						45. DATE REC'D. BY REGISTRAR APR 11 1985		46. REGISTRAR'S SIGNATURE		
47. ADDRESS 4739 Baltimore Ave. Hyattsville, Md. 20781										

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 28 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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JAN 21 1964

JAN 21 1964

GEORGE'S COUNTY



PO BOX 10000

STATE

PO BOX 10000

Handwritten text, possibly a signature or address, including the word "George's" and "County".

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

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(VR A15 ME (1))
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 1 2 2 5 7			
1. FOR STATE REGISTRAR		UNKN. #85-31		DECEASED NAME (TYPE OR PRINT) Robert James Ellworth						2a. DATE KNOWN OF DEATH X MONTH DAY YEAR 4/11/ 19 85		2b. HOUR M 3:42	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 11 10 44		6. AGE (IN YEARS LAST BIRTHDAY) 40 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD 4/11/1985	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County, MD.			
10. CITY OR TOWN OF DEATH Beltsville				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Amtrak Railroad Tracks				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 00000			
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Unkn.				(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO. 563-62-6652		17. INFORMANT ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Injuries DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 8:35 PM 4/11/ 19 85		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject struck by train							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) railroad tracks		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Amtrak Railroad Tracks, Beltsville, Md.							
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural cause <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE				TITLE (SPECIFY) M.D. Assistant				DATE SIGNED 4/11/85					
EXAMINER'S NAME (TYPE OR PRINT) Gregory R. Kauffman, M.D.				ADDRESS 111 Penn St.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal				23b. DATE 4/16/85		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME Anatomy Board				ADDRESS Balto., Md.				25a. DATE REC'D BY REGISTRAR APR 18 1985		25b. REGISTRAR'S SIGNATURE Julia Davidson-Rendall			

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

25

12258

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LAWRENCE Wilbur ENGLEMAN			2a. DATE OF DEATH MONTH DAY YEAR 04 01 85			2b. HOUR 9:20AM				
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 4 1909		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD.				
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (GIVE FULL NAME AND FIVE STREET ADDRESS) PRINCE GEORGES GENERAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Optician		12b. KIND OF BUSINESS OR INDUSTRY Self Employed		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										
13a. STATE Maryland		13b. COUNTY Prince George		13c. CITY OR TOWN Lanham		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 7623 Finns Lane 20706	
14. FATHER'S NAME FIRST MIDDLE LAST David I. Engleman				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST May Connolly						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 578-26-0687		17. INFORMANT ADDRESS Mary E Engleman, Same as item 13.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF (b) Severe COPD DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Left ventricular and right ventricular myocardial dysfunction										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 3/13 , 19 85 , to 4/1 , 19 85 , that (I) (we) last saw the deceased alive on 3/31 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Gerardo M. Gacad				DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/1/85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GERARDO M. GACAD				22e. ADDRESS 6492 Landover Rd. Landover MD 20785						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 4/3/1985		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood, Maryland.			
24. FUNERAL DIRECTOR NAME ADDRESS Joseph Gawler's Sons Inc. 5130 Wisc. Ave., N.W. Wash., D.C.						25a. DATE REC'D. BY REGISTRAR APR 04 1985		25b. REGISTRAR'S SIGNATURE John Davidson-Rendall		

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• 2011 100th Anniversary of the 1911 Revolution

U.S. National Archives
College Park, Maryland

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119070

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
FIRST MIDDLE LAST ELMIRA EPPERSON			MONTH DAY YEAR 4-10-85			4.30PM		
3. SEX FEMALE			4. RACE BLACK			5. DATE OF BIRTH		
			MONTH DAY YEAR 12-20-20			6. AGE (IN YEARS LAST BIRTHDAY)		
						64 YRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		
9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S								
10. CITY OR TOWN OF DEATH CHEVERLY			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION PRINCE GEORGE'S GENERAL HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) DIETITIAN		
						12b. KIND OF BUSINESS OR INDUSTRY HOSPITALS		
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)								
13a. STATE MARYLAND			13b. COUNTY D. G.			13c. CITY OR TOWN Seat Pleasant		
						13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST HENRY EPPERSON			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST WILLIE IDA BANKS					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 324-26-8115			17. INFORMANT JAMES EPPERSON - Seat Pleasant, MD.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>METASTATIC COLON CANCER</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>SEPSIS</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION CITY OR TOWN COUNTY STATE		
22. certify that (I) (this hospital) attended the deceased from <u>4/10/85</u> 19 <u>85</u> to <u>4/11/85</u> 19 <u>85</u> , that (I) (we) lost view of the deceased on <u>4/11/85</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE K. SUDHAKAR			DEGREE			22c. DATE SIGNED 4/12/85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS 7676 NEW HAMPSHIRE AVE #400 LANGLEY PARK MD 20263					
23a. BURIAL, CREMATION, REMOVAL BURIAL			23b. DATE 4/15/85			23c. NAME OF CEMETERY OR CREMATORY HARMONY		
23d. LOCATION CITY OR TOWN COUNTY STATE LANDOVER P.G. MD.			24. FUNERAL DIRECTOR NAME ROLLINS			25a. DATE REC'D BY REGISTRAR APR 19 1985		
25b. REGISTRAR'S SIGNATURE Jana Davidson-Randall								

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SECTION 1

SECTION 2

SECTION 3

SECTION 4

SECTION 5

SECTION 6

127099

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 2 2 6 0

1 DECEASED NAME (TYPE OR PRINT) CHARLES EUGENE ETHERTON			2a DATE OF DEATH MONTH DAY YEAR APRIL 27, 1985		2b HOUR 10:27A M
3 SEX MALE	4 RACE WHITE	5 DATE OF BIRTH MONTH DAY YEAR November 28, 1942		6 AGE (IN YEARS LAST BIRTHDAY) 42 YRS. MONTHS DAYS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) ILLINOIS	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD.	
10 CITY OR TOWN OF DEATH FORESTVILLE	11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4020 SUIT ROAD		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) C.P.A.		12b KIND OF BUSINESS OR INDUSTRY Self Employed
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE MARYLAND			13b COUNTY PR. GEORGE		13c CITY OR TOWN FORESTVILLE
14 FATHER'S NAME FIRST MIDDLE LAST ROSCOE ETHERTON			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ETHEL BENJAMIN		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b SOCIAL SECURITY NO. 337-36-1217		17 INFORMANT ADDRESS MRS. VALERIE L. ETHERTON, SAME AS #13	
18 CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) CARCINOMA OF THE LUNG & METASTASIS DUE TO, OR AS A CONSEQUENCE OF (c) 3 1/2 mos.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1-2 hrs
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from 8/6 19 82 to 4/27 19 85 that (I) (we) lost saw the deceased alive on 4/27 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE Ch. Colao		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 4/27/85	
22d PHYSICIAN'S NAME (TYPE OR PRINT) CHARLES F. COLAO, M.D.			22e ADDRESS 3710 Riviera St, Marlow Heights, Md. 20748		
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b DATE Apr. 29, 1985		23c NAME OF CEMETERY OR CREMATORY CALEDONIA CEMETERY,	
23d LOCATION CITY OR TOWN COUNTY STATE SPARTA, RANDOLPH, ILLINOIS		25a DATE REC'D. BY REGISTRAR MAY 2 1985			
24 FUNERAL DIRECTOR NAME LEE FUNERAL HOME,		ADDRESS 6633 Old Alex- ander Ferry Rd., Clinton, Maryland 20735		25b REGISTRAR'S SIGNATURE Julia Davidson-Randall	

RELEASED BY DR. RODRIGUEZ, DEPUTY MEDICAL EXAMINER

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked "c", it must be noted that any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1 2 2 6 1

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
George F. Farmer								4-20		19		85				M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 24 HRS.		7c. DATE PRONOUNCED		MONTH		DAY		YEAR		2d. HOUR	
Male	Black	7/ 23/ 1914		70 YRS.				4-30		19		85				M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH								MD	
Maryland		United States		WIDOWED		DIVORCED		Prince Geo's									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Clinton		Southern Maryland Hospital		Laborer		Farming											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
Maryland		Prince Geo's		Aguasco		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		15604 Dr. Bowen Rd.									

1. FATHER'S NAME		FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME		FIRST		MIDDLE		LAST	
Samuel						Farmer		Estelle						Edelen	

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
No		579 16 2926		Ethel Farmer		SAA	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Ante-mortem cerebro-cardiovascular disease			
DUE TO, OR AS A CONSEQUENCE OF			
(b)			
DUE TO, OR AS A CONSEQUENCE OF			
(c)			

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		TITLE (SPECIFY) Deputy		DATE SIGNED 4-20-85	
ACTUAL SIGNATURE Augusto P. Rodriguez		M.D.		MEDICAL EXAMINER	
EXAMINER'S NAME (TYPE OR PRINT)		Augusto P. Rodriguez, M.D.		ADDRESS 5009 Rayburn Ct., Temple Hills, Md	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		4/ 23/ 85		St. Peter's Ch. Cem.		Chas. Waldorf Md	
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Martell G. Adams		Aguasco, Md.		APR 26 1985		Julia Davidson-Rendell	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 12 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP
DHMH - 17
(VR A15 ME (5))

7

CHIEF

MINISTER

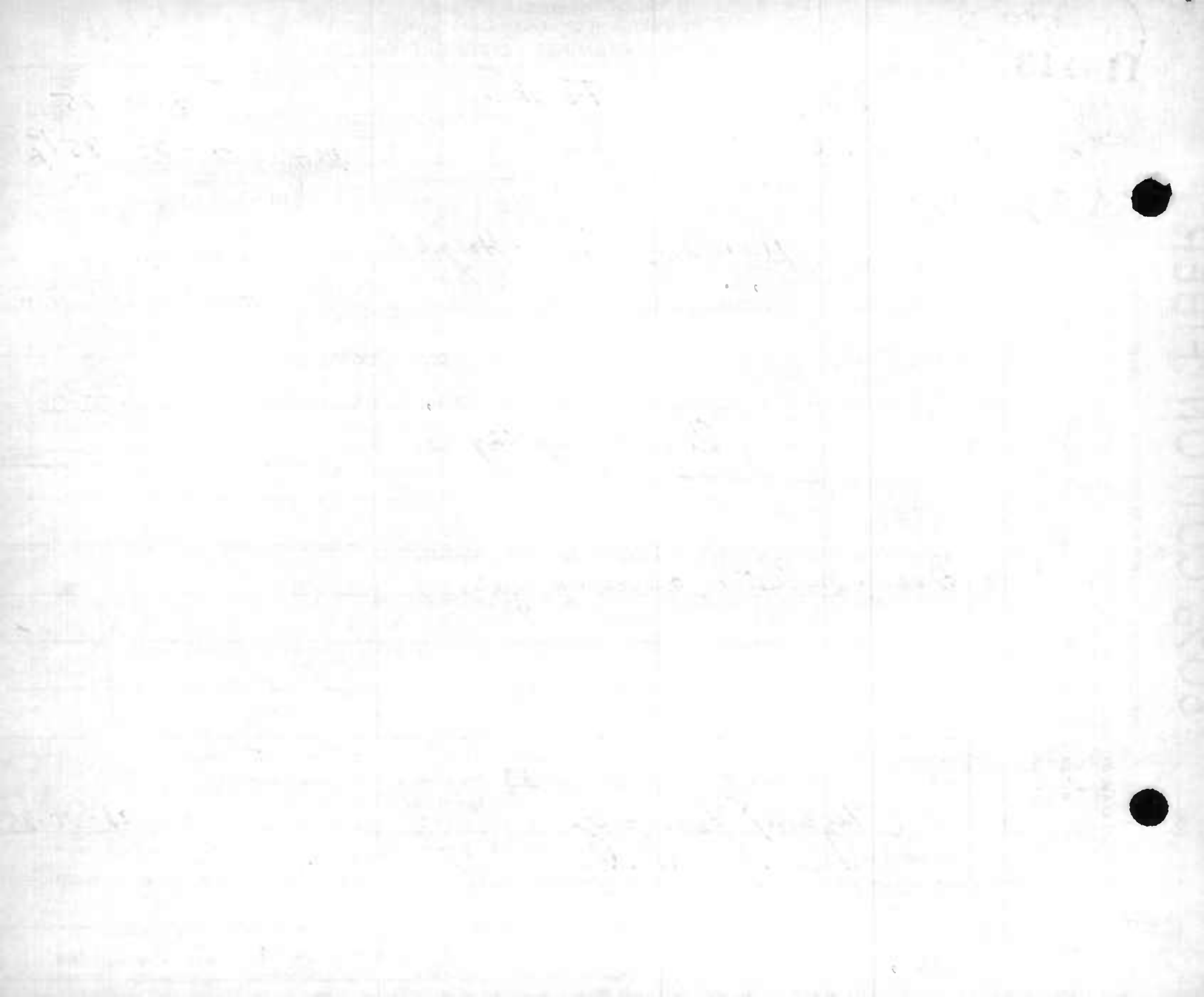
OF

2020-11-03

2020

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR 1- STATE REGISTRAR										STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										1 2 2 6 2 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		FIRST <i>Paul</i>		MIDDLE		LAST <i>Faulkner</i>		2a. DATE KNOWN OF DEATH		MONTH <i>4</i>		DAY <i>20</i>		YEAR <i>1985</i>		2b. HOUR <i>12</i>					
3. SEX <i>Male</i>		4. RACE <i>Black</i>		5. DATE OF BIRTH MONTH <i>12</i> DAY <i>20</i> YEAR <i>36</i>		6. AGE (IN YEARS) LAST BIRTHDAY <i>48</i> YRS.		IF UNDER 1 YR. MONTHS <i></i> DAYS <i></i>		IF UNDER 24 HRS. HOURS <i></i> MIN <i></i>		7c. DATE PRONOUNCED MONTH <i>4</i> DAY <i>20</i> YEAR <i>1985</i>		2d. HOUR <i>12</i>							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Virginia</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		7. BALTIMORE CITY OR COUNTY OF DEATH <i>Prince Georges</i> MD															
1d. CITY OR TOWN OF DEATH <i>PG</i>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Prince Georges General Hospital</i>										17a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Government Worker</i>		17b. KIND OF BUSINESS OR INDUSTRY <i>None</i>							
13a. STATE <i>Maryland</i>		13b. COUNTY <i>P.G.</i>		13c. CITY OR TOWN <i>Landover</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>4092 Warner Ave</i>		13f. CITY OR TOWN <i>Maryland</i>		13g. STATE <i>Landover</i>									
14. FATHER'S NAME FIRST <i>Pool</i> MIDDLE <i>Gray</i>		15. MOTHER'S MAIDEN NAME FIRST <i>Gora</i> MIDDLE <i>Brown</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>Yes</i>		16b. SOCIAL SECURITY NO. <i>2</i>		17. INFORMANT <i>Mrs. Lucille Gray</i>		ADDRESS <i>1231 44 Pl SE</i>											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiomyopathy</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I <i>Diabetes mellitus cardiac irregularity</i>																					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M.</i> <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)																	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE																	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																					
ACTUAL SIGNATURE <i>Augusto P. Rodriguez</i>		TITLE (SPECIFY) <i>Deputy</i>		M.D.		MEDICAL EXAMINER		DATE SIGNED <i>4-20-85</i>													
EXAMINER'S NAME (TYPE OR PRINT) <i>Augusto P. Rodriguez, M.D.</i>		ADDRESS <i>5009 Rayburn Ct., Temple Hills, Md</i>																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>27/4/1985</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Harmony Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Landover Maryland</i>															
24. FUNERAL DIRECTOR NAME <i>Dudley, S Fun Home Inc</i>		ADDRESS <i>1425 Maryland Ave</i>		25. DATE REC'D. BY REGISTRAR <i>APR 22 1985</i>		25b. REGISTRAR'S SIGNATURE <i>Davidson-Randall</i>															



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
 STATE
 REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) CHARLES H. FLYNN			2a DATE OF DEATH MONTH DAY YEAR 4/8/85		2b HOUR 4:24p.m.	
3 SEX Male		4 RACE Caucasian		5 DATE OF BIRTH MONTH DAY YEAR April 10, 1904		
6 AGE (IN YEARS LAST BIRTHDAY) 80 YRS.		7a CITIZEN OF WHAT COUNTRY? USA		7b MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
8 BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD.				
10 CITY OR TOWN OF DEATH CLINTON		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTHERN MARYLAND HOSPITAL CENTER		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Truck driver		
12b KIND OF BUSINESS OR INDUSTRY St. Hwy. Ad.						
13a STATE Maryland			13b CITY OR TOWN Charles White Plains		13c STREET ADDRESS / ZIP CODE P. O. Box 16D 20695	
14 FATHER'S NAME FIRST MIDDLE LAST Joseph William Flynn			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ann Carrie Line Scott			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b SOCIAL SECURITY NO. 220-01-4399		17 INFORMANT Son Roger Flynn ADDRESS 7711 Poplar Hill Clinton, MD 20735		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Severe Refractory Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (b) Severe Diabetic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes Mellitus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (if)						
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED [ENTER NATURE OF INJURY IN ITEM 18 (a) OR PART 2]		
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE		
22a I certify that (1) (this hospital) attended the deceased from 1983 to 4/8 19 85 , that (1) (we) lost saw the deceased alive on 4/8 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (2) (we) did not view the body after death.						
22b SIGNATURE G. H. WATKINS		DEGREE ATTENDING PHYSICIAN		22c DATE SIGNED 4/8/85		
22d PHYSICIAN'S NAME (TYPE OR PRINT) G. H. WATKINS		22e ADDRESS Waldorf 20601				
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 4/11/85		23c NAME OF CEMETERY OR CREMATORY St. Joseph's Cemetery Pomeroy Charles MD		
24 FUNERAL DIRECTOR Huntt Funeral Home, Waldorf, MD		25a DATE REC'D. BY REGISTRAR APR 10 1985				
		25b REGISTRAR'S SIGNATURE Gina Davidson-Randall				

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH1 2 2 6 4
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>William T Ford</i>			2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR <i>April 26 1985</i>		2b. HOUR OF DEATH MINUTE <i>12:30 PM</i>	
3. SEX <i>M</i>	4. RACE <i>BLK</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>Sept 17 32</i>	6. AGE (IN YEARS) LAST BIRTHDAY <i>52 YRS.</i>	7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	8. IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <i>April 26 1985</i>
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>S. CAROLINA</i>		9b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Prince Georges MD</i>
10. CITY OR TOWN OF DEATH <i>Riverview</i>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Keloland Home Hosp</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>TRUCK DRIVER</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>CONSTRUCTION</i>
13a. STATE <i>MD</i>			13b. COUNTY <i>Prince Georges</i>	13c. CITY OR TOWN <i>Arundel</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <i>3162 Arundel Pk</i>
14. FATHER'S NAME FIRST MIDDLE LAST <i>ZACK FORD</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>BURGESS</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>No</i>			16b. SOCIAL SECURITY NO. <i>249-46-5374</i>		17. INFORMANT ADDRESS <i>ETHEL MAE FORD - 3103 ARUNDEL RD.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Myocardial Dis.</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <i>None</i>						
19a. DATE OF OPERATION <i>None</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .						
ACTUAL SIGNATURE <i>[Signature]</i>		TITLE (SPECIFY) M.D. <i>Dep</i>		MEDICAL EXAMINER DATE SIGNED <i>April 26 1985</i>		
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		23b. DATE <i>5-2-85</i>		23c. NAME OF CEMETERY OR CREMATORY <i>FT. LINCOLN COM.</i>		
23d. LOCATION CITY OR TOWN COUNTY STATE <i>BRENTWOOD MD.</i>		24. FUNERAL DIRECTOR NAME <i>JOHN T. RHINES</i>		25a. DATE REC'D. BY REGISTRAR <i>APR 30 1985</i>		
25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>						

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD, 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25MBP
DHMH - 17
(VR A15 ME (5))

(1)

(2)

WILLIAM

SECTION 2

TEST 2

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH VITAL RECORDS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M
 BP _____
 DHMH - 17
 (VR A15 ME (5))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 1 2 2 6 6	
1- FOR STATE REGISTRAR										2a. DATE KNOWN OF DEATH	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Emma Lee Franklin										2b. HOUR OF DEATH 12:00 P.M.	
3. SEX F.		4. RACE W.		5. DATE OF BIRTH MONTH DAY YEAR June 9-04-80		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD April 26, 1985		7d. HOUR OF DEATH 12:00 P.M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASH. D.C.				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD	
10. CITY OR TOWN OF DEATH Laurel				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greider Laurel Bldg				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) OPERATOR-RET.		12b. KIND OF BUSINESS OR INDUSTRY TELEPHONE (SWITCH BOARD)	
13. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										12c. ADDRESS	
13a. STATE Md.		13b. COUNTY P. G. C.		13c. CITY OR TOWN LAUREL		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 69 South BRUCE ST.		20707	
14. FATHER'S NAME FIRST MIDDLE LAST PATRICK J. SULLIVAN										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EMMA FERGURSON	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No										16b. SOCIAL SECURITY NO. 578-18-3237	
17. INFORMANT ADDRESS THEODORE H. FRANKLIN (SAME AS #13)											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Dis. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I None											
19a. DATE OF OPERATION None				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE [Signature]				TITLE (SPECIFY) M.D. Dep.				MEDICAL EXAMINER DATE April 26 1985			
EXAMINER'S NAME (TYPE OR PRINT) JOHN S. ROGERS				ADDRESS 1919 SEMINARY RD. S.S. Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 4-30-1985		23c. NAME OF CEMETERY OR CREMATORY MT. OLIVET CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE WASHINGTON, D.C.			
24. FUNERAL DIRECTOR NAME W.W. CHAMBERS				ADDRESS 5801 CLEVELAND AVE RIVERDALE, Md 20737		25a. DATE REC'D. BY REGISTRAR MAY 1 1985		25b. REGISTRAR'S SIGNATURE [Signature]			

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STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 2 2 6 1

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Andrew Frazier			2a. DATE OF DEATH MONTH DAY YEAR April 9, 1985			2b. HOUR A.M. 1:10					
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR April 8 1985		6. AGE (IN YEARS (LAST BIRTHDAY)) YRS. MONTHS DAYS 2 13		7. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? America		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD.		10. CITY OR TOWN OF DEATH Clinton			
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Maryland Hosp. Center			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) None			12b. KIND OF BUSINESS OR INDUSTRY			13. STREET ADDRESS 2582 Sussex Court		
13a. STATE Maryland			13b. COUNTY Charles			13c. CITY OR TOWN Waldorf			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST John Warren Gibson			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lori Elaine Frazier			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. None		
17. INFORMANT ADDRESS Mother 2582 Sussex Ct. Waldorf, Md.			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity DUE TO, OR AS A CONSEQUENCE OF (b) Premature Labor DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Ronald T. Zielinsky MD			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 4-12-85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Ronald T. Zielinsky, M.D.			22e. ADDRESS 7501 Surratts Rd. Clinton, Md. 20735								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE		
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR APR 19 1985			25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall		

MEDICAL CERTIFICATION

2 2 9

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 states any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

DHMH - 16 50M 1/81
(VRA 15, 4)



128069

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) James Albert Frye			2a. DATE OF DEATH MONTH DAY YEAR April 29, 1985		2b. HOUR PM 2:30	
3. SEX Male		4 RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR February 26, 1924		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
10 CITY OR TOWN OF DEATH Bowie			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 12323 Whitehall Drive			
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mechanic			12b. KIND OF BUSINESS OR INDUSTRY Automotive			
13a. STREET ADDRESS / ZIP CODE 12323 Whitehall Drive 20715			13b. CITY OR TOWN Bowie			
14. FATHER'S NAME FIRST MIDDLE LAST Lee Rose			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Laura Watkins			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II 577-40-1543			
17 INFORMANT ADDRESS Jessie R. Frye 12323 Whitehall Drive Bowie, Maryland 20715						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiac arrhythmia DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Chronic Lymphocytic Leukemia						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART I OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (1) this hospital attended the deceased from Jan 1, 1985 to 4/20, 1985 that (1) (we) last saw the deceased alive on April 11, 1985 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Robert Ruderman				22c. DATE SIGNED 5/1/85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Robert Ruderman, M.D.				22e. ADDRESS 6201 Greenbelt Road College Park, MD		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE May 2, 1985		23c. NAME OF CEMETERY OR CREMATORY Maryland Veterans Cem.		
23d. LOCATION CITY OR TOWN COUNTY STATE Cheltenham, Pr. George's, MD		24 FUNERAL DIRECTOR NAME Beall Funeral Home		25a. DATE REC'D. BY REGISTRAR MAY 6 1985		
25b. REGISTRAR'S SIGNATURE [Signature]						

Cleared by: Dr. John S. Rogers, M.D., D.M.E. April 29, 1985

MEDICAL CERTIFICATION

000831

THE UNIVERSITY OF CHICAGO

273

released.

10 4591, 4600, 4601, 4602, 4603, 4604, 4605, 4606, 4607, 4608, 4609, 4610, 4611, 4612, 4613, 4614, 4615, 4616, 4617, 4618, 4619, 4620, 4621, 4622, 4623, 4624, 4625, 4626, 4627, 4628, 4629, 4630, 4631, 4632, 4633, 4634, 4635, 4636, 4637, 4638, 4639, 4640, 4641, 4642, 4643, 4644, 4645, 4646, 4647, 4648, 4649, 4650, 4651, 4652, 4653, 4654, 4655, 4656, 4657, 4658, 4659, 4660, 4661, 4662, 4663, 4664, 4665, 4666, 4667, 4668, 4669, 4670, 4671, 4672, 4673, 4674, 4675, 4676, 4677, 4678, 4679, 4680, 4681, 4682, 4683, 4684, 4685, 4686, 4687, 4688, 4689, 4690, 4691, 4692, 4693, 4694, 4695, 4696, 4697, 4698, 4699, 4700, 4701, 4702, 4703, 4704, 4705, 4706, 4707, 4708, 4709, 4710, 4711, 4712, 4713, 4714, 4715, 4716, 4717, 4718, 4719, 4720, 4721, 4722, 4723, 4724, 4725, 4726, 4727, 4728, 4729, 4730, 4731, 4732, 4733, 4734, 4735, 4736, 4737, 4738, 4739, 4740, 4741, 4742, 4743, 4744, 4745, 4746, 4747, 4748, 4749, 4750, 4751, 4752, 4753, 4754, 4755, 4756, 4757, 4758, 4759, 4760, 4761, 4762, 4763, 4764, 4765, 4766, 4767, 4768, 4769, 4770, 4771, 4772, 4773, 4774, 4775, 4776, 4777, 4778, 4779, 4780, 4781, 4782, 4783, 4784, 4785, 4786, 4787, 4788, 4789, 4790, 4791, 4792, 4793, 4794, 4795, 4796, 4797, 4798, 4799, 4800, 4801, 4802, 4803, 4804, 4805, 4806, 4807, 4808, 4809, 4810, 4811, 4812, 4813, 4814, 4815, 4816, 4817, 4818, 4819, 4820, 4821, 4822, 4823, 4824, 4825, 4826, 4827, 4828, 4829, 4830, 4831, 4832, 4833, 4834, 4835, 4836, 4837, 4838, 4839, 4840, 4841, 4842, 4843, 4844, 4845, 4846, 4847, 4848, 4849, 4850, 4851, 4852, 4853, 4854, 4855, 4856, 4857, 4858, 4859, 4860, 4861, 4862, 4863, 4864, 4865, 4866, 4867, 4868, 4869, 4870, 4871, 4872, 4873, 4874, 4875, 4876, 4877, 4878, 4879, 4880, 4881, 4882, 4883, 4884, 4885, 4886, 4887, 4888, 4889, 4890, 4891, 4892, 4893, 4894, 4895, 4896, 4897, 4898, 4899, 4900, 4901, 4902, 4903, 4904, 4905, 4906, 4907, 4908, 4909, 4910, 4911, 4912, 4913, 4914, 4915, 4916, 4917, 4918, 4919, 4920, 4921, 4922, 4923, 4924, 4925, 4926, 4927, 4928, 4929, 4930, 4931, 4932, 4933, 4934, 4935, 4936, 4937, 4938, 4939, 4940, 4941, 4942, 4943, 4944, 4945, 4946, 4947, 4948, 4949, 4950, 4951, 4952, 4953, 4954, 4955, 4956, 4957, 4958, 4959, 4960, 4961, 4962, 4963, 4964, 4965, 4966, 4967, 4968, 4969, 4970, 4971, 4972, 4973, 4974, 4975, 4976, 4977, 4978, 4979, 4980, 4981, 4982, 4983, 4984, 4985, 4986, 4987, 4988, 4989, 4990, 4991, 4992, 4993, 4994, 4995, 4996, 4997, 4998, 4999, 5000, 5001, 5002, 5003, 5004, 5005, 5006, 5007, 5008, 5009, 5010, 5011, 5012, 5013, 5014, 5015, 5016, 5017, 5018, 5019, 5020, 5021, 5022, 5023, 5024, 5025, 5026, 5027, 5028, 5029, 5030, 5031, 5032, 5033, 5034, 5035, 5036, 5037, 5038, 5039, 5040, 5041, 5042, 5043, 5044, 5045, 5046, 5047, 5048, 5049, 5050, 5051, 5052, 5053, 5054, 5055, 5056, 5057, 5058, 5059, 5060, 5061, 5062, 5063, 5064, 5065, 5066, 5067, 5068, 5069, 5070, 5071, 5072, 5073, 5074, 5075, 5076, 5077, 5078, 5079, 5080, 5081, 5082, 5083, 5084, 5085, 5086, 5087, 5088, 5089, 5090, 5091, 5092, 5093, 5094, 5095, 5096, 5097, 5098, 5099, 5100, 5101, 5102, 5103, 5104, 5105, 5106, 5107, 5108, 5109, 5110, 5111, 5112, 5113, 5114, 5115, 5116, 5117, 5118, 5119, 5120, 5121, 5122, 5123, 5124, 5125, 5126, 5127, 5128, 5129, 5130, 5131, 5132, 5133, 5134, 5135, 5136, 5137, 5138, 5139, 5140, 5141, 5142, 5143, 5144, 5145, 5146, 5147, 5148, 5149, 5150, 5151, 5152, 5153, 5154, 5155, 5156, 5157, 5158, 5159, 5160, 5161, 5162, 5163, 5164, 5165, 5166, 5167, 5168, 5169, 5170, 5171, 5172, 5173, 5174, 5175, 5176, 5177, 5178, 5179, 5180, 5181, 5182, 5183, 5184, 5185, 5186, 5187, 5188, 5189, 5190, 5191, 5192, 5193, 5194, 5195, 5196, 5197, 5198, 5199, 5200, 5201, 5202, 5203, 5204, 5205, 5206, 5207, 5208, 5209, 5210, 5211, 5212, 5213, 5214, 5215, 5216, 5217, 5218, 5219, 5220, 5221, 5222, 5223, 5224, 5225, 5226, 5227, 5228, 5229, 5230, 5231, 5232, 5233, 5234, 5235, 5236, 5237, 5238, 5239, 5240, 5241, 5242, 5243, 5244, 5245, 5246, 5247, 5248, 5249, 5250, 5251, 5252, 5253, 5254, 5255, 5256, 5257, 5258, 5259, 5260, 5261, 5262, 5263, 5264, 5265, 5266, 5267, 5268, 5269, 5270, 5271, 5272, 5273, 5274, 5275, 5276, 5277, 5278, 5279, 5280,

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Abstract

• Information 0008 1

Real World Time

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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DHMH - 16 60M 7/84
(VRA 15, 4)

101006

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										1 2 2 6 9	
1 - FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST BERTHA T. FULLER					2a. DATE OF DEATH MONTH DAY YEAR 04 02 85			2b. HOUR 1 10A M			
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR June 18 1917		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD.					
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PGG HOSPITAL AND MEDICAL CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housekeeper		12b. KIND OF BUSINESS OR INDUSTRY Domestic			
13a. STATE PA		13b. COUNTY Delaware		13c. CITY OR TOWN Philadelphia		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Hazel Hurst Street 99999			
14. FATHER'S NAME FIRST MIDDLE LAST William Jones				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rita Smith							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-20-9363		17. INFORMANT ADDRESS Hazel Mumford, Bishopville, MD							
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 Day 1 Day			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Organic Brain Syndrome</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>4/1</u> 19 <u>85</u> to <u>4/1</u> 19 <u>85</u> , that (I) (we) lost saw the deceased alive on <u>4/1</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If not, state) (did not view the body after death).											
22b. SIGNATURE <u>Stuart Turkewitz</u>					DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/2/85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stuart Turkewitz					22e. ADDRESS 2500 Greenway Center Dr. Greenbelt, Md - 20770.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 4-6-85		23c. NAME OF CEMETERY OR CREMATORY Evergreen		23d. LOCATION CITY OR TOWN COUNTY STATE Berlin Worcester MD				
24. FUNERAL DIRECTOR <u>Charles W. Hartz, Sellyville, Pa.</u>					25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE APR 8 1985 <u>John H. ...</u>						

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Request may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

101006



106147

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

12270

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LUCILLE LAVONNA GANT			2a. DATE OF DEATH MONTH DAY YEAR April 8, 1985		2b. HOUR 11:40am
3. SEX F	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR Oct. 22, 1926		6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, DC	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD.	
10. CITY OR TOWN OF DEATH LANHAM	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DOCTORS' HOSPITAL of P.G. CO.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. CITY OR TOWN P.G.	13c. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO	13d. STREET ADDRESS / ZIP CODE 1077 Largo Road 20772	
14. FATHER'S NAME FIRST MIDDLE LAST William Arstead Lewis			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Georgia Lewis		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 578 30 8962		17. INFORMANT ADDRESS Deatria Williams-daughter-7623 Muncy Road, Hyattsville, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) respiratory-cardiac failure DUE TO, OR AS A CONSEQUENCE OF (b) metastatic breast cancer DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost					APPROXIMATE INTERVAL BETWEEN CAUSE AND DEATH 1hr 1hr
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 85 Feb , 19 85 , to April , 19 85 , that (we) lost saw the deceased alive on April 8 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Martin D. Wertz M.D.		DEGREE		22c. DATE SIGNED 4/8/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARTIN D. WERTZ		22e. ADDRESS 7535 Greenway Ctr Drive Greenbelt MD 20770			
23a. BURIAL, CREMATION, REMOVAL Cremation		23b. DATE April 13, 1985		23c. NAME OF CEMETERY OR CREMATORY Lee's Crematorium	
23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.		23e. NAME OF CEMETERY OR CREMATORY Harmony Memorial Park, Landover, Maryland			
23f. FUNERAL HOME Stewart Funeral Home-4001 Benning Road, N.E.		APR 11 1985			

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

10017



Cleared by Dr. Rodriguez D.M.E.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 1 2 2 7 1	
1. DECEASED NAME (TYPE OR PRINT) Jeanne S. Gardiner						2a. DATE OF DEATH MONTH DAY YEAR April 9, 1985			2b. HOUR AM 9:00 M		
1. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Nov. 29, 1922		6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Michigan		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges County MD					
10. CITY OR TOWN OF DEATH Bowie		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2814 Bosworth Lane				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker			12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Prince Georges 13c. CITY OR TOWN Bowie						13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2814 Bosworth Lane 20715			
14. FATHER'S NAME FIRST MIDDLE LAST Steuart Arthur Shannon						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Pauline Barnes					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		(IF YES, GIVE WAR OR CAUSE) - - -		16b. SOCIAL SECURITY NO. 379-12-7444		17. INFORMANT ADDRESS William B. Gardiner same as 13e					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) HYPERTENSIVE CARDIOVASCULAR DISEASE										15 YEARS	
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (was hospital) attended the deceased from JULY 19 68 to FEB 19 85 , that (I) (was) lost saw the deceased alive on FEB 20 85 , and that in (my) (own) opinion death occurred on the date and hour and from the causes stated above, (I) (we did) (did not) view the body after death.											
22b. SIGNATURE Norman K. Bohrer MD						DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED APRIL 9, 1985	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) NORMAN K. BOHRER						22e. ADDRESS 3231 SUPERIOR LANE Bowie, MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE April 10, 1985		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory			23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, Virginia			
24. FUNERAL DIRECTOR NAME Beall Funeral Home			ADDRESS 16000 Annapolis Road Bowie, Maryland 20715			25. DATE REC'D. BY REGISTRAR APR 15 1985		25b. REGISTRAR'S SIGNATURE William B. Gardiner			

BP

105143

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 2 2 7 2

1. DECEASED NAME (TYPE OR PRINT) Esther E. Garrison		2a. DATE OF DEATH MONTH DAY YEAR 4-1-85		2b. HOUR MIN. 9:10 P.M.	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR August 28, 1902	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 82	
10. CITY OR TOWN OF DEATH Clinton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Clinton Convalescent Center		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County, MD.	
13a. STATE Maryland		13b. COUNTY Charles		13c. CITY OR TOWN Waldorf	
14. FATHER'S NAME FIRST MIDDLE LAST George H. Bayliss		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma J. Grimsley		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Domestic	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT ADDRESS Paul Garrison - Same As #13 A-E	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF (b) Severe Cardiac Valvular Abnormalities DUE TO, OR AS A CONSEQUENCE OF (c) 					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 1/2 years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 2-22-82 to 4-1-85 , that (I) (we) lost saw the deceased alive on 3-15-85 , and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
27b. SIGNATURE Richard Dobson, M.D.				27c. DATE SIGNED 4-1-85	
27d. PHYSICIAN'S NAME (TYPE OR PRINT) Richard Dobson, M.D.				27e. ADDRESS Brandywine-Waldorf Clinic Brandywine, Maryland	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE April 5, 1985		23c. NAME OF CEMETERY OR CREMATORY National Memorial Park Falls Church, Virginia	
24. FUNERAL DIRECTOR NAME Lee Funeral Home, Inc.		25a. DATE REC'D. BY REGISTRAR APR 9 1985		25b. REGISTRAR'S SIGNATURE Richard Dobson-Randall	

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BP

DHMH - 16 50M 4/82

(VRA 15, 4)

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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7



CHIEF
SUPERVISOR

126058

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- STATE REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST <i>Joseph</i>		MIDDLE <i>J.</i>		LAST <i>Gertson</i>		2a. DATE KNOWN OF DEATH ESTI-MATED		MONTH <i>4</i>		DAY <i>24</i>		YEAR <i>1985</i>		2b. HOUR <i>10</i>	
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH <i>5</i> DAY <i>15</i> YEAR <i>1966</i>		6. AGE (IN YEARS) LAST BIRTHDAY <i>18</i> YRS		IF UNDER 1 YR. MONTHS <i>0</i> DAYS <i>0</i>		IF UNDER 24 HRS HOURS <i>0</i> MIN <i>0</i>		7c. DATE PRONOUNCED DEAD <i>4-24-85</i>		MONTH <i>4</i>		DAY <i>24</i> YEAR <i>1985</i>	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>WASHINGTON DC.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		8. MARRIED WIDOWED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>PRINCE GEORGES MD.</i>											
10. CITY OR TOWN OF DEATH <i>CHEVERLY</i>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS <i>Prince Georges General Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>STUDENT</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>SCHOOL</i>											
13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <i>MD.</i>		13b. COUNTY <i>PG</i>		13c. CITY OR TOWN <i>LAUREL</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <i>6913 FITZPATRICK DR.</i>									
14. FATHER'S NAME FIRST <i>JOHN</i>		MIDDLE <i>GERTSON</i>		LAST <i>MARY</i>		15. MOTHER'S MAIDEN NAME FIRST <i>ANNE</i>		MIDDLE <i>SMITH</i>		LAST <i>SMITH</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>NO</i>		16b. SOCIAL SECURITY NO. <i>215-98-1965</i>		17. INFORMANT ADDRESS <i>MARY GERTSON SAME AS 13e</i>													
18. CAUSE OF DEATH (Enter only one cause in line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Multiple injuries with skull fractures</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):																	
19a. DATE OF OPERATION <i>4-16-85</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <i>Injuries.</i>												20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>5:00 PM 4 7 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <i>operation/motorcycle/hit fixed objects</i>													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <i>Street</i>		21f. LOCATION STREET <i>6400 Black Rock Rd.</i> CITY OR TOWN <i>Prince Georges</i> COUNTY <i>MD.</i> STATE													
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion																	
ACTUAL SIGNATURE <i>Augusto P. Rodriguez</i>		TITLE (SPECIFY) <i>Deputy</i>		M.D.		MEDICAL EXAMINER		DATE SIGNED <i>4-25-85</i>									
EXAMINER'S NAME (TYPE OR PRINT) <i>Augusto P. Rodriguez, M.D.</i>		ADDRESS <i>5009 Rayburn Ct., Temple Hills, Md</i>															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		23b. DATE <i>4/27/85</i>		23c. NAME OF CEMETERY OR CREMATORY <i>MEADOWRIDGE Mem Pk</i>		23d. LOCATION CITY OR TOWN <i>BALTIMORE</i>		COUNTY <i>MARYLAND</i>		STATE							
24. FUNERAL DIRECTOR NAME <i>FIECK FUNERAL HOME INC.</i>		ADDRESS <i>7601 SANDY SPRING Rd. LAUREL MD.</i>		25a. DATE REC'D. BY REGISTRAR <i>MAY 1 1985</i>		25b. REGISTRAR'S SIGNATURE <i>Felia Davidson-Randall</i>											

07/84
25M

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DHMH - 17
(VR A15 ME (5))

(Faint handwritten text, possibly a date or reference number)

(Faint handwritten text, possibly a name or title)



(Faint handwritten text, possibly a date or reference number)

(Faint handwritten text, possibly a signature or name)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

DHMH - 17
(VR A15 ME (5))
20M 4/B2

DHMH - 17
(VR A15 ME (5))
20M 4/B2

MEDICAL CERTIFICATION

MEDICAL CERTIFICATION

10

ROLLINS FUNERAL HOME, INC.
4339 HUNT PLACE, N.E.
WASHINGTON, D.C. 20013

John S. Rogers, N.D.

1919 Seminary Road
Silver Spring, Md.

Deputy

None

None

None

Carcinoma of the lung.

5-1-38

William A. Allen

Miss

Miss

Thorton

Prince George's

3210 Johnson Court

Doctor's Hospital

3210 Johnson Court

Prince George's

Prince George's

Prince George's

Prince George's

Prince George's

Prince George's

Prince George's

Prince George's

134004

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED. WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR STATE REGISTRAR		2- DATE OF DEATH MONTH DAY YEAR 4-28 1985										2b HOUR 6:09 PM															
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YR. MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN		9. BALTIMORE CITY OR COUNTY OF DEATH							
RAYMOND E. GLASCOE								male		white		Aug 27, 1923		61 YRS.						Prince Georges MD							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		13a. STREET ADDRESS		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		14. FATHER'S NAME (TYPE OR PRINT)		15. MOTHER'S MAIDEN NAME (TYPE OR PRINT)		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		17. INFORMANT ADDRESS					
Clinton		Southern Maryland Hospital		Truck Driver		Oil Company		8233 Allenton Road		PG		Ft Washington		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Raymond E. Glascoe		Elsie Griffith		NO		Margaret A Glascoe same as 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that I took charge of the remains described above, held on death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22b. DATE		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION CITY OR TOWN COUNTY STATE	
PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease																											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: aspiration, obesity																											
ACTUAL SIGNATURE		EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS		TITLE (SPECIFY)		DATE SIGNED		23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		24. FUNERAL DIRECTOR NAME		25. REGISTERAR'S SIGNATURE		26. REGISTERAR'S SIGNATURE					
Augusto P. Rodriguez		Augusto P. Rodriguez, M.D.		5009 Rayburn Ct. Camp Springs, Md 20748		Deputy		4-29-85		Burial		5/1/85		Washington National		Suitland PG MD		Robert E. Wilhelm Funeral Home		MAY 09 1985		Julia Davidson-Randall					

07/84
25M

BP

DHMH - 17
(VR A15 ME (5))

131004

93013 101103 & 02

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1- FOR
STATE
REGISTRAR

REG. NO.

DECEASED NAME (TYPE OR PRINT) KARL DALY GLASS, JR.			2a. DATE OF DEATH MONTH DAY YEAR APRIL 3, 1985		2b. HOUR 12 N M	
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR Jan. 3, 1934		6. AGE (IN YEARS LAST BIRTHDAY) 51 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Arkansas	7b. CITIZEN OF WHAT COUNTRY? USA.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD.		
10. CITY OR TOWN OF DEATH LANHAM	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DOCTORS' HOSPITAL of P.G. Co.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Attorney		12b. KIND OF BUSINESS OR INDUSTRY U.S. Government	
13a. STATE Maryland	13b. COUNTY Anne Arundel	13c. CITY OR TOWN Annapolis	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 2625 Greenbriar Lane 21401		
14. FATHER'S NAME FIRST MIDDLE LAST Karl Daly Glass Sr.		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jessie Austin				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 431-54-3259		17. INFORMANT ADDRESS Joanna Glass (wife) Same as #13 a&e		

18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED

21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

CITY OR TOWN

COUNTY

STATE

22a. I certify that (1) this hospital attended the deceased from 4/3 1985 to 4/3 1985, that (2) (we) last
saw the deceased alive on 4/3 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above; (3) we did not view the body after death.

22b. SIGNATURE

DEGREE

ATTENDING
PHYSICIANMEDICAL
DIRECTORSTAFF
PHYSICIAN

22c. DATE SIGNED

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

22e. ADDRESS

Lewis H. Dennis, MD**831 University Blvd. E. Silver Spring, MD 20903**23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Removal to23b. DATE
4 Apr 85

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION
CITY OR TOWN

COUNTY

STATE

Paris, Arkansas

24. FUNERAL DIRECTOR

NAME

CAPITOL FUNERAL SERVICE

ADDRESS

Falls Church, Virginia

25a. DATE REC'D. BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

APR 9 1985**John Davidson-Randall**

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 2 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Samantha J Gordon			2a. DATE OF DEATH MONTH DAY YEAR April 14, 1985		2b. HOUR P M 2:10 P		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept. 16, 1901		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS MONTHS DAYS MINS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George MD.	
10. CITY OR TOWN OF DEATH Hyattsville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3900 Hamilton Street		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. STATE Maryland		13b. COUNTY P.G.		13c. CITY OR TOWN Hyattsville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE 3900 Hamilton Street 20781		14. FATHER'S NAME FIRST MIDDLE LAST John Irving Johnson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Catherine Stevens		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	
16b. SOCIAL SECURITY NO. 223-03-5974		17. INFORMANT 7102 Webster Street Albert Mitchell Landover Hills, Md. 20784		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Vascular Disease</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Multistable Cerebral Vascular Disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Immunos</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Immediate</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>NA</i>							
19a. DATE OF OPERATION <i>N/A</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>N/A</i>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>N/A</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) this hospital attended the deceased from 2-14-85 , 19 85 , to 4-14 , 19 85 , that (b) (we) last saw the deceased on 4-1 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (do not) view the body after death.							
22b. SIGNATURE <i>Daniel J. Boyle</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/15/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Daniel J. Boyle M.D.				22e. ADDRESS 10313 Georgia Ave. #201 Silver Spring, Md. 20902			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/16/85		23c. NAME OF CEMETERY OR CREMATORY Fort Hill Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Lynchburg (N/A) Virginia	
24. FUNERAL DIRECTOR Francis Gasch's Sons Funeral Home P.A. 4739 Baltimore Ave. Hyattsville, Md. 20781				25a. DATE REC'D. BY REGISTRAR APR 18 1985		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) GRAY, NORMAN SR.				2a. DATE OF DEATH MONTH DAY YEAR 04 26 85		2b. HOUR 12:45AM	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR October 29, 1917		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, DC		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S MD.	
10. CITY OR TOWN OF DEATH Clinton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Md Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Typesetter		12b. KIND OF BUSINESS OR INDUSTRY Printing	
13a. STATE Maryland				13b. COUNTY Prince George's		13c. CITY OR TOWN Ft. Washington	
14. FATHER'S NAME FIRST MIDDLE LAST John Henry Gray				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hallie Wood			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII 577-03-3507		17. INFORMANT ADDRESS Lois A. Gray - Same As #13 A-E			
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pulmonary emphysema</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Carcinoma of Lung</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION 3-25-85		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Lung Cancer Chemotherapy		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from <u>3-21</u> , 19 <u>85</u> , to <u>4-26</u> , 19 <u>85</u> , that (I) (we) lost saw the deceased alive on <u>4-25</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we did) (did not) view the body after death.							
22b. SIGNATURE William Kent Furst MD				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4-26-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) W. Furst M.D.				22e. ADDRESS 11701 Livingston Rd. Ft. Wash. Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE April 29, 1985		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, Maryland	
24. FUNERAL DIRECTOR NAME Lee Funeral Home, Inc. ADDRESS 16638 Old Alexander Ferry Road, Clinton, Maryland				25a. DATE REC'D. BY REGISTRAR MAY 2 1985		25b. REGISTRAR'S SIGNATURE John Anderson-Pendell	

MEDICAL CERTIFICATION

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified on duty.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) JAHROD R. GREEN										2a. DATE OF DEATH KNOWN <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> MONTH DAY YEAR 3 30 19 85	
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 07 07 1984		6. AGE (IN YEARS) LAST BIRTHDAY MONTHS DAYS YRS. 8 23		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 3 30 19 85	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Dist. of Col.				7b. CITIZEN OF WHAT COUNTRY? U.S.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD.				10. CITY OR TOWN OF DEATH Camp Springs				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Andrews Air Force Base Hosp.			
12a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE D.C.				13b. COUNTY				13c. CITY OR TOWN Washington			
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS 2424 Elvans Rd, SE #302 20020				12b. KIND OF BUSINESS OR INDUSTRY N/A			
14. FATHER'S NAME FIRST MIDDLE LAST Unknown				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Linda Green				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO			
16b. SOCIAL SECURITY NO. N/A				17. INFORMANT ADDRESS Linda Green 2424 Elvans Rd, SE #302				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 7980 Sudden Infant Death Syndrome Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ (c) _____			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>Ann M. Dixon</i>				TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER				DATE SIGNED 3-31-85			
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.				ADDRESS 111 Penn St., Balto., Md. 21201							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 04-03-85		23c. NAME OF CEMETERY OR CREMATORY Harmony Mem. Park				23d. LOCATION CITY OR TOWN COUNTY STATE Landover PG Maryland	
24. FUNERAL DIRECTOR NAME Robert G. Mason ADDRESS 1661 Wood Hope Rd. SE						25a. DATE REC'D. BY REGISTRAR APR 9 1985		25b. REGISTRAR'S SIGNATURE <i>Julian Davidson</i>			

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FOR
1. STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

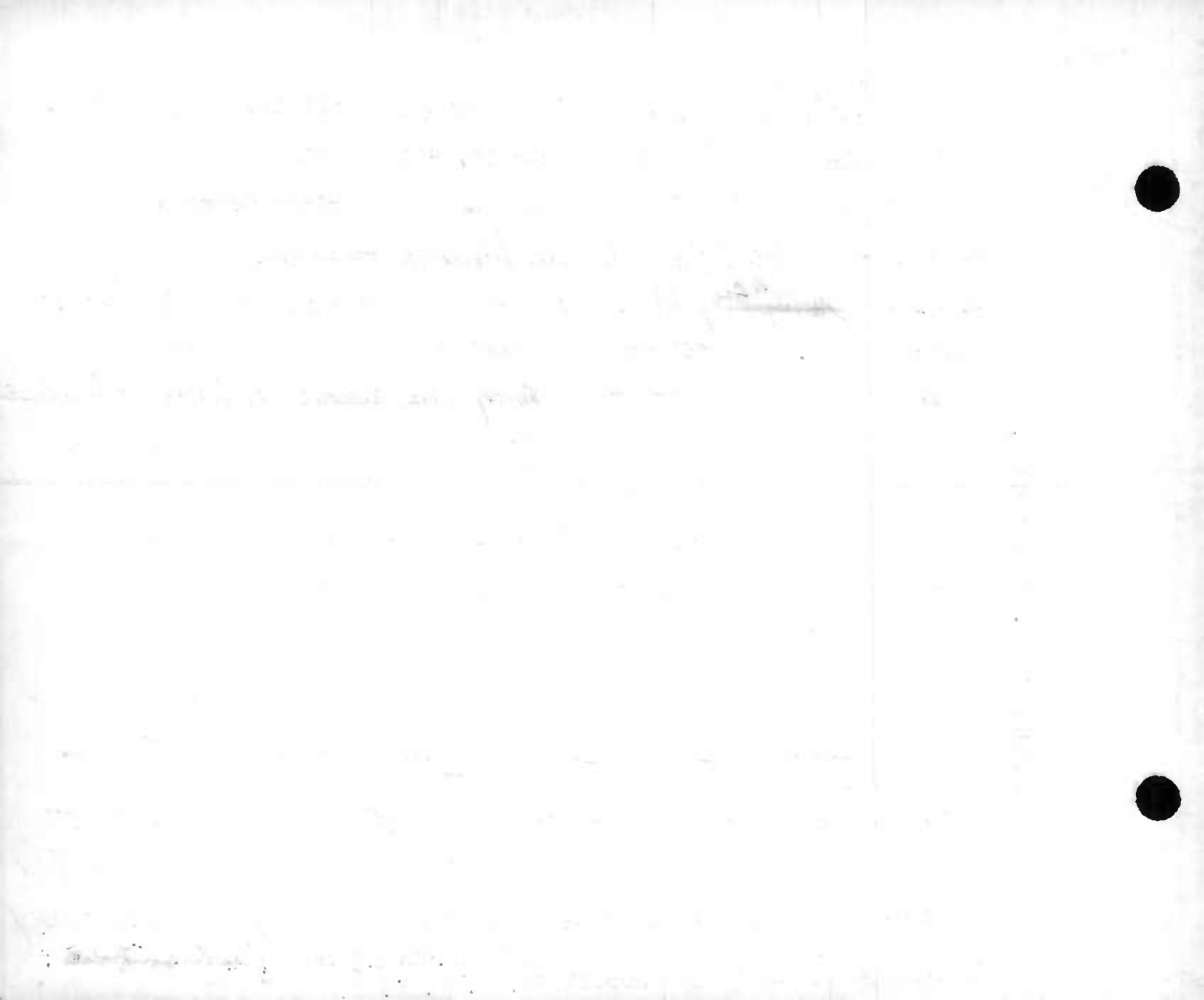
1. DECEASED NAME (TYPE OR PRINT) Beatrice S. Greenman				2a. DATE OF DEATH MONTH DAY YEAR April 11, 1985		2b. HOUR 1 A.M.	
3. SEX F. Female		4. RACE W. White		5. DATE OF BIRTH MONTH DAY YEAR August 16, 1893		6. AGE (IN YEARS LAST BIRTHDAY) 91 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey		7b. CITIZEN OF WHAT COUNTRY? U S A		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD.	
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 603 Ethan Allen Ave Takoma Pk.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Takoma Park		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST John S. Silver		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lovina Adams		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 125-05-4310	
17. INFORMANT ADDRESS TIMOTHY KANE, EXECUTOR, 101 N. ADAMS ST. ROCKVILLE							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>respiratory arrest (aspiration)</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>advanced senescence</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>generalized arteriosclerosis</u>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes years years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>marked scoliosis and kyphosis of chest, osteoarthritis.</u>							
19a. DATE OF OPERATION N/A.		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT HOME <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) <u>this hospital</u> attended the deceased from <u>1970</u> to <u>4.11</u> , 19 <u>85</u> , that (1) <u>four</u> last saw the deceased alive on <u>4.5</u> , 19 <u>85</u> , and that in (my) <u>best</u> opinion death occurred on the date and hour and from the causes stated above, (1) <u>four</u> (did) (did not) view the body after death.							
22b. SIGNATURE Frederic W. Brennwald MD.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4.11.85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) F.W. BRENNWALD MD				22e. ADDRESS 831 University Ave E. S.S. Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE APRIL 13, 1985		23c. NAME OF CEMETERY OR CREMATORY ARLINGTON CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE Kearny NEW JERSEY	
24. FUNERAL DIRECTOR'S NAME Takoma Funeral Home		24b. ADDRESS 254 Carroll St. N. W. D. C.		25. DATE REC'D. BY REGISTRAR APR 12 1985		25b. REGISTRAR'S SIGNATURE Julia Davidson	

RELEASED BY DR. JOHN ROGERS, MEDICAL EXAMINER

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. (IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, all medical findings must be verified at once.)



BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
Catherine Elizabeth Grindler					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) <i>Catherine Elizabeth Grindler</i>					2a. DATE OF DEATH MONTH DAY YEAR <i>4-27-85</i>			2b. HOUR <i>1156 P.M.</i>	
3. SEX <i>Female</i>		4. RACE <i>Caucasian</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>Sept. 29, 1901</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>83</i>		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>PRINCE GEORGES COUNTY MD.</i>			
10. CITY OR TOWN OF DEATH <i>CLINTON MD</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <i>SOUTHERN MARYLAND HOSPITAL</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Powder Worker</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>U.S. N.O.S. Govt.</i>	
13a. STATE <i>Maryland</i> 13b. COUNTY <i>Charles</i> 13c. CITY OR TOWN <i>Indian Head</i>					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>37 Cypress Place 20640</i>		
14. FATHER'S NAME FIRST MIDDLE LAST <i>William Joseph Mattingly</i>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Mary E. Higdon</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>218-30-3102</i>		17. INFORMANT ADDRESS <i>Rt. 2, Box 39 Charles W. Dudley, Indian Head, Md.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory Failure</i>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO, OR AS A CONSEQUENCE OF (b) <i>Chronic Obstructive Lung Disease</i>									
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Essential Asthma</i>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>Arteriosclerotic Heart Disease, Diabetes Mellitus</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from <i>4-26</i> , 19 <i>85</i> , to <i>4-27</i> , 19 <i>85</i> , that (I) (we) last saw the deceased alive on <i>4-27</i> , 19 <i>85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) could not view the body after death, so state.)									
22b. SIGNATURE <i>R. A. McConnaughy M.D.</i> DEGREE					22c. DATE SIGNED <i>4/27/85</i>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>R. A. McConnaughy, M.D. P.A.</i>					22e. ADDRESS <i>5618 St. Barnabas Rd. Oxon Hill, Md.</i>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>5-1-85</i>		23c. NAME OF CEMETERY OR CREMATORY <i>St. Charles Cem.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Indian Head, Chas. Md.</i>			
24. FUNERAL DIRECTOR NAME <i>The Hunt Funeral Home, Waldorf, Md.</i> ADDRESS					25a. DATE REC'D. BY REGISTRAR <i>MAY 1 1985</i> 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>				

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1 - STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) MILDRED GROSS			2a. DATE OF DEATH MONTH DAY YEAR 03-29-85		2b. HOUR 4 15PM	
3. SEX FEMALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR JULY 7, 1914		
6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		8. CITIZEN OF WHAT COUNTRY? U. S. A.		
9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD.		10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S GENERAL HOSP.		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) UNEMPLOYED		12b. KIND OF BUSINESS OR INDUSTRY NONE		13a. STATE MD.		
13b. COUNTY P.G.		13c. CITY OR TOWN CEONIA HTS.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET ADDRESS / ZIP CODE 908 CYPRESS STREET DR. 20745		14. FATHER'S NAME FIRST MIDDLE LAST HARRY SCOTT		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARTHA COLE		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. UNKNOWN		17. INFORMANT ADDRESS CHARLES GALLION - SAME AS #13 ABOVE		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory arrest DUE TO, OR AS A CONSEQUENCE OF (b) Pneumonia DUE TO, OR AS A CONSEQUENCE OF (c) Carcinoma of Lung					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 1						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from 3/26, 1985 to 3/29, 1985 , that (I) (we) last saw the deceased alive on 3/29, 1985 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE S. NAYAK		DEGREE		22c. DATE SIGNED 3/30/85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) S. NAYAK		22e. ADDRESS PESH + MC Cheverly, Md				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 4/3/85		23c. NAME OF CEMETERY OR CREMATORY HARMONY MEM. PARK		
23d. LOCATION CITY OR TOWN COUNTY STATE CANDOVER P.G. Co.		24. FUNERAL DIRECTOR NAME ADDRESS H. S. WASHINGTON & SONS 4925 BURGESS AVE.				

BP

APR 08 1985
John C. ...

1-701023

DATE

NAME

01-01-01

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THE CHURCH OF JESUS CHRIST OF LATTER-DAY SAINTS

W. J. W.

PER OF THE

106066

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 4/83
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) William J. Guthrie			2a. DATE OF DEATH MONTH DAY YEAR April 5, 1985			7b. HOUR 7:00 a.m.			
3. SEX Male		4. RACE White		5. DATE OF BIRTH December 3, 1919		6. AGE (IN YEARS LAST BIRTHDAY) 65		7. UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Massachusetts		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD			
10. CITY OR TOWN OF DEATH Riverdale		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Leland Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Attorney		12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't.	
13a. STATE Maryland			13b. COUNTY P.G.		13c. CITY OR TOWN Cheverly		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST William J. Guthrie Sr.			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillian Brennick						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII & Korea 011 14 0243			17. INFORMANT ADDRESS Frances K. Guthrie Same as 13e			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatic-Renal Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cirrhosis of Liver</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Ethanol Intake</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> <u>6 weeks</u> <u>2 yrs</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: 11a									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>3-1-85</u> , 19 <u>85</u> , to <u>4-5</u> , 19 <u>85</u> , that (I) (we) lost saw the deceased alive on <u>4-4</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Thomas M. Hutchins</u>			DEGREE <u>M.D.</u>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>4/5/85</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Thomas M. Hutchins, M.D.			22e. ADDRESS 6214 Landover Road, Hyattsville, Md. 20785						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 4/9/85		23c. NAME OF CEMETERY OR CREMATORY Md. Veterans Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Cheltenham P.G. Maryland		
23e. NAME OF FUNERAL HOME Francis Gasch's Sons Funeral Home P.A. 4739 Baltimore Avenue Hyattsville, Md. 20781					23f. DATE RECD. BY REGISTRAR APR 11 1985		23g. REGISTRAR'S SIGNATURE <u>[Signature]</u>		

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) MARIE L. HAERINGER			2a. DATE OF DEATH MONTH DAY YEAR 03-29-85			2b. HOUR 5 15PM			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 10 30 86		6. AGE (IN YEARS LAST BIRTHDAY) 98 YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) France		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD.			
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S GENERAL HOSP.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY PG		13c. CITY OR TOWN Upper Marlboro		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST Jean Castagnet		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown Unknown		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO					
16b. SOCIAL SECURITY NO. Unknown		17. INFORMANT NAME ADDRESS Jean J Naylor same as #13							
18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c.) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF SEPSIS (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROPRIATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (i) (this hospital) attended the deceased from 3/29 19 85 to 3/29 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (i) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Mark Parikhurst				DEGREE M.D.		22c. DATE SIGNED 3/29/85		22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARK PARIKHURST M.D.	
22e. ADDRESS 7100 BALT AVG COLLEGE PARK MD									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/2/85		23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Washington DC			
24. FUNERAL DIRECTOR NAME ADDRESS Robert E. Wilhelm Funeral Home Suitland				25. DATE REC'D. BY REGISTRAR APR 10 1985		25a. REGISTRAR'S SIGNATURE J. L. ...			

105115

POLICE OFFICE



OFFICE OF THE ATTORNEY GENERAL

STATE OF NEW YORK

105115

OFFICE OF THE ATTORNEY GENERAL

STATE OF NEW YORK

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) GRACE E HALL			2a DATE OF DEATH MONTH DAY YEAR 04 22 85		2b HOUR 5:45P
1 SEX Female	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR May 24, 1903		6 AGE (IN YEARS (LAST BIRTHDAY)) 81 YRS.	
7a BIRTHPLACE (COUNTRY) Maryland	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE MD.	
10 CITY OR TOWN OF DEATH Clinton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Maryland Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Seamstress		12b KIND OF BUSINESS OR INDUSTRY D.C. General Hospital
13a. STATE Maryland			13b. CITY OR TOWN Prince George's Indian Head	13c STREET ADDRESS / ZIP CODE Box 71-Z (20640)	
14 FATHER'S NAME FIRST MIDDLE LAST George E. Medley			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret E. Lyon		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17 INFORMANT 5812 Kirby Road Joe Medley - Clinton, Maryland 20735	

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Respiratory failure DUE TO, OR AS A CONSEQUENCE OF (b) Viral Pneumonia DUE TO, OR AS A CONSEQUENCE OF (c) 		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
Renal failure

19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 3 130 185	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE 8926 Woodyard Rd. Clinton, MD 20735	
22a. I certify that (I) (this hospital) attended the deceased from 3/30/85 to 4/22/85 , that (I) (we) last saw the deceased alive on 4/22/85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
22b SIGNATURE Venkat Mani		DEGREE M-D ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 4/23/85
22d. PHYSICIAN'S NAME (TYPE OR PRINT) VENKAT MANI MD		22e. ADDRESS 8926 Woodyard Rd. Clinton, MD 20735	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE April 26, 1985	23c. NAME OF CEMETERY OR CREMATORY St. Charles Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Glymont, Maryland
24. FUNERAL DIRECTOR NAME ADDRESS Lee Funeral Home, Inc. Old Alexander Ferry Road, Clinton, Maryland		25a. DATE REC'D. BY REGISTRAR APR 25 1985	
		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed within 72 hours after death. It should be detached for use at the funeral home permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death. with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in writing.

MEDICAL CERTIFICATION



2/2/72

M.D. K

W. J. ...

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105131

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) EILEEN A HANCOCK			2a. DATE OF DEATH MONTH 04 DAY 02 YEAR 85			2b. HOUR 4:45AM				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH January DAY 8 YEAR 1920		6. AGE (IN YEARS (LAST BIRTHDAY)) 65 YRS.		IF UNDER 1 YEAR MONTHS 0 DAYS 0 HOURS 0 MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S MD.				
10. CITY OR TOWN OF DEATH CLINTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Md Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary		12b. KIND OF BUSINESS OR INDUSTRY USGov't		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Pr George		13c. CITY OR TOWN Suitland		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4810 Bennett Ave 20746	
14. FATHER'S NAME FIRST Michael MIDDLE Casey LAST Casey			15. MOTHER'S MAIDEN NAME FIRST Mary MIDDLE O'Toole LAST O'Toole							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 205 10 6203		17. INFORMANT Marilynn H. McNulty		ADDRESS 717 Carson Ave Oxon Hill, Md				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute, severe Anteroseptic DUE TO, OR AS A CONSEQUENCE OF Myocardial Infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF _____								APPROXIMATE INTERVAL BETWEEN DEATH AND DEATH 6 days		
PART 2 (OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 4/1 1985		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) 3/27 1985						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET Waldorf Rd		CITY OR TOWN Suitland		COUNTY PG		
21g. STATE Md										
22a. I certify that (I) (this hospital) attended the deceased from 3/27 19 85 to 4/2 19 85 , that (I) (we) last saw the deceased alive on 4/1 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE G. H. WATKIN				DEGREE ATTENDING PHYSICIAN				22c. DATE SIGNED 4/2/85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) G. H. WATKIN				22e. ADDRESS Waldorf Rd 20607						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5Apr1985		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN Suitland		COUNTY PG		
23e. STATE Md										
24. FUNERAL DIRECTOR NAME Robert E Wilhelm Funeral Home				ADDRESS Suitland, Md		25a. DATE REC'D. BY REGISTRAR APR 10 1985		25b. REGISTRAR'S SIGNATURE John D. ...		

MEDICAL CERTIFICATION

BP

DHMH - 16 60M 7/84
(VRS 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by phone.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

100% COTTON FIBRE

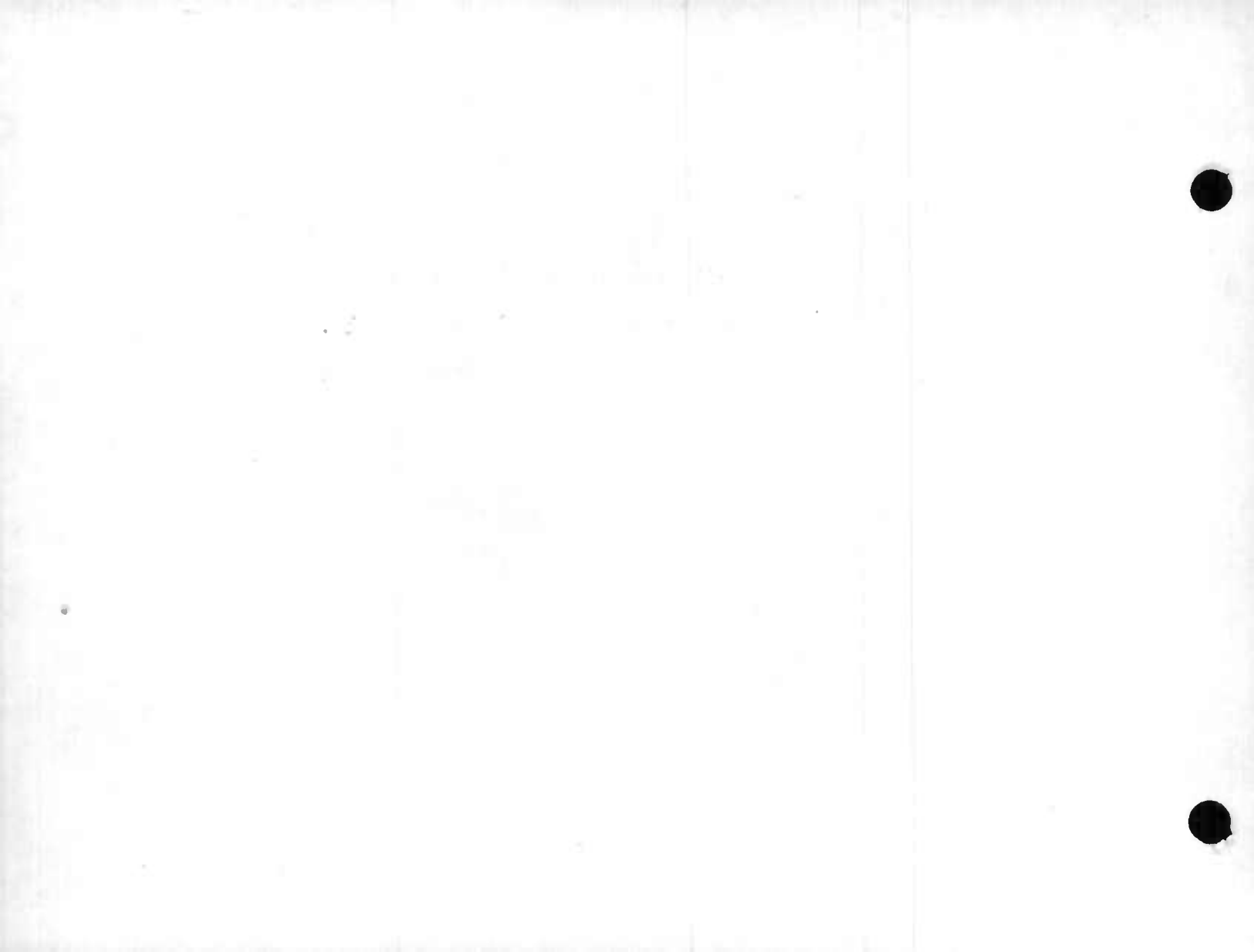
MADE IN INDIA



100% COTTON FIBRE
MADE IN INDIA
GIL

VOIDED April, 1985 Certificate Number - Death

85-12287 See May, 1985 James Hancock, 5/4/85 - P.G.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) Katherine Conahan HANLON			2a. DATE OF DEATH April 26 1985			2b. HOUR 9:45p.M.				
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH March 12, 1901		6. AGE (IN YEARS LAST BIRTHDAY) 84		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.				
10. CITY OR TOWN OF DEATH Lanham		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Doctors' Hospital of Pr. Geo. Co.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY Nursing		
13a. STATE Maryland			13b. COUNTY Prince Georges		13c. CITY OR TOWN Bowie		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 12205 Mackell Lane 20715	
14. FATHER'S NAME FIRST MIDDLE LAST Patrick J. Conahan			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Mooney							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no			16b. SOCIAL SECURITY NO. 188-36-1670		17. INFORMANT Katherine F. Brennan				ADDRESS same as 13e	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ATELECTASIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u>PERFORATED GASTRIC ULCER</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs.</u> <u>1 WEEK</u>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>SYNTHETRIC TACHYCARDIA; HYPERNATREMIA, AZOTEMIA, SEPSIS.</u>										
19a. DATE OF OPERATION 4/20/85			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED PERFORATED GASTRIC ULCER			19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		19d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)					
21a. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21c. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from <u>4/20</u> 19 <u>85</u> to <u>4/26</u> 19 <u>85</u> that (1) (my) last saw the deceased alive on <u>4/26</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above.										
22b. SIGNATURE <u>[Signature]</u>			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/27/85		
23a. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERTO A. DEPETRI			23b. ADDRESS 14300 GALLANT FOX LA #122 Bowie Md 20710							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal-Burial			23b. DATE April 30 1985		23c. NAME OF CEMETERY OR CREMATORY St. Marys Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Hanover Luzerne Pennsylvania			
24. FUNERAL DIRECTOR NAME Beall Funeral Home			16000 Annapolis Road Bowie, Maryland			25a. DATE REC'D. BY REGISTRAR APR 29 1985		25b. REGISTRAR'S SIGNATURE Jana Davidson-Randall		

100-36-100

Female

Education

March 12, 1901

31

Pennsylvania, USA

USA

X

Refined

Butler

Maryland

Prince Georges County

X

12301 Macmillan Lane

20115

Station

Commercial

Anna

Montgomery

no

100-36-100

Katherine F. Brennan

same as life

120942

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a death certificate must be filed within 72 hours after death.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ANNIE HARIAN				2a. DATE OF DEATH MONTH DAY YEAR APRIL 14, 1985			
3 SEX FEMALE		4 RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 1 31 97		6. AGE (IN YEARS LAST BIRTHDAY) 88	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) GA.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD.	
10. CITY OR TOWN OF DEATH HYATTSVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MANISON MANOR		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
13a. STATE MO		13b. COUNTY P.G.		13c. CITY OR TOWN Seag Pleasant		13e. STREET ADDRESS 1418 Nye St. 20743	
14. FATHER'S NAME FIRST MIDDLE LAST Allen BURNS				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 577030839		17. INFORMANT ADDRESS Evelyn Missouri-DAUGHTER			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-Pulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Cerebro Vascular disease DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes Mellitus PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Vaginitis, Dementia.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 3-1 , 19 85 , to 4-14 , 19 85 , that (I) (we) lost saw the deceased alive on 4-14 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE B. Carra				DEGREE MD		22c. DATE SIGNED 4/14/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE April 19, 1985		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood, Maryland	
24. FUNERAL DIRECTOR NAME Stewart Funeral Home-4001 Benning Road, NE				25a. DATE REC'D. BY REGISTRAR APR 23 1985		25b. REGISTRAR'S SIGNATURE Wardson-Randall	

BP

DHMH - 16 60M 7/73
(VRA 15 (4))

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1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARJORIE D HARNIS			2a. DATE OF DEATH MONTH DAY YEAR APRIL 3, 1985		2b. HOUR 1:00p M		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 02 15 1911		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kentucky		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD.	
10. CITY OR TOWN OF DEATH LANHAM		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DOCTORS' HOSPITAL OF P.G. CO.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) School teacher		12b. KIND OF BUSINESS OR INDUSTRY P.G. School System	
13a. STATE Maryland		13b. COUNTY P.G.		13c. CITY OR TOWN Hyattsville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE 3901 Van Buren Street 20782		14. FATHER'S NAME FIRST MIDDLE LAST Louis Rosenfield		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Florida Dorn Lasley			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 220-38-2505		17. INFORMANT ADDRESS Patricia Orndorff (Friend) Same as 13e			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular arrest DUE TO, OR AS A CONSEQUENCE OF (b) Septic shock DUE TO, OR AS A CONSEQUENCE OF (c) 24-36 h Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: chronic renal failure							
19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 4/2 , 19 85 , to 4/3 , 19 85 , that (I) (we) last saw the deceased alive on 4/3 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.							
22b. SIGNATURE [Signature]		DEGREE MD.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/4/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Steven M. Pollak		22e. ADDRESS 4700 Arth Place CAMP Spg					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 4/5/85		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood P.G. Maryland	
24. FUNERAL DIRECTOR'S NAME Francis C. Gesch's Sons Funeral Home, P.A.				25a. DATE REC'D. BY REGISTRAR APR 11 1985		25b. REGISTRAR'S SIGNATURE [Signature]	
4739 Baltimore Avenue Hyattsville, Md. 20781							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

100144

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25MBP
DHMH - 17
(VR A15 ME (5))1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST Oteila			MIDDLE Harris			LAST Harris			2a. DATE KNOWN OF DEATH ESTIMATED			MONTH 4			DAY 9			YEAR 1985			2b. HOUR M		
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 10-4-38			6. AGE (IN YEARS) LAST BIRTHDAY 46 YRS.			IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7c. DATE PRONOUNCED MONTH DAY YEAR 10-4-85			2d. HOUR M			2e. HOUR M						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia				7b. CITIZEN OF WHAT COUNTRY? U.S.A				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges														
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince Georges General Hospital								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bishop				12b. KIND OF BUSINESS OR INDUSTRY CHURCH										
13a. STATE MD.				13b. COUNTY P.G.				13c. CITY OR TOWN CAPITOL HGTs				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS 212 ZELMA AVE.										
14. FATHER'S NAME FIRST MIDDLE LAST CHARLES Williams						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ADELE HALL																				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO						16b. SOCIAL SECURITY NO. UNKNOWN						17. INFORMANT ADDRESS CLARENCE A. HARRIS 212 ZELMA AVE MD.														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE Diabetic atherosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:																										
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH						21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19						21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)														
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>						21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)						21f. LOCATION STREET CITY OR TOWN COUNTY STATE														
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																										
ACTUAL SIGNATURE Augusto P. Rodriguez						TITLE (SPECIFY) Deputy						MEDICAL EXAMINER DATE SIGNED 4-5-85														
EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez, MD.						ADDRESS 5009 Rayburn Ct., Temple Hills, Md																				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL						23b. DATE 4-9-85						23c. NAME OF CEMETERY OR CREMATORY HARMONY CEM						23d. LOCATION CITY OR TOWN COUNTY STATE								
24. FUNERAL DIRECTOR NAME MODERN FUNERAL Home						ADDRESS 3821-14th ST N.W. D.C.						25a. DATE REC'D. BY REGISTRAR APR 8 1985						25b. REGISTRAR'S SIGNATURE Lidia Davidson-Randall								

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130023

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST <i>Boyd</i> MIDDLE <i>Charles</i> LAST <i>Hayes</i> <i>Boyd Charles Hayes</i>				2a. DATE OF DEATH MONTH DAY YEAR <i>26 Apr 85</i> <i>4 26 85</i>				2b. HOUR MIN. <i>10 30 A</i>	
3. SEX <i>Male</i>		4. RACE <i>Caucasian</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>Nov. 9, 1907</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>77</i> YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>South Carolina</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Prince Georges Co.,</i> MD.			
10. CITY OR TOWN OF DEATH <i>Greenbelt</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Greenbelt Nursing Center</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Butcher</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Food</i>	
13a. STATE <i>Maryland</i>				13b. COUNTY <i>Prince Georges Greenbelt</i>		13c. CITY OR TOWN <i>Greenbelt</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Burnie P. Hayes</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Minnie Swintz</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>yes</i>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>Unavailable</i>		17. INFORMANT ADDRESS <i>Lydelle Hayes (brother) Lake View, S.C.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>ASCD</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>immediate</i> <i>years</i>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>Constrictive Heart Failure, Pleural Effusion</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, EARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>4/24</i> 19 <i>85</i> to <i>4/25</i> 19 <i>85</i> , that (I) (we) last saw the deceased alive on <i>4/25</i> 19 <i>85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>D Granite MD</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <i>4/26/85</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>D Granite MD</i>				22e. ADDRESS <i>115 Centerway Greenbelt Md</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>28 Apr 85</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Lake View Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Lake View, South Carolina</i>			
24. FUNERAL DIRECTOR NAME <i>Capitol Funeral Service, Falls Church, VA</i>				25a. DATE REC'D. BY REGISTRAR <i>MAY 8 1985</i>		25b. REGISTRAR'S SIGNATURE <i>Lake View, South Carolina</i>			

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

150051

121048

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Daniel M. Hawkins			2a. DATE OF DEATH MONTH DAY YEAR 4/19/85		2b. HOUR 9:25A M
3. SEX Male	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 1/ 19/ 1911	6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES COUNTY MD.		
10. CITY OR TOWN OF DEATH CLINTON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTHERN MARYLAND HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Inspector	12b. KIND OF BUSINESS OR INDUSTRY Gas Light Co.	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE Maryland	13b. COUNTY Prince Geo's	13c. CITY OR TOWN Brandywine	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET ADDRESS / ZIP CODE 6801 Floral Park Rd. 20613	
14. FATHER'S NAME FIRST MIDDLE LAST Carroll Hawkins		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mamie Moore			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 578 07 3018	17. INFORMANT ADDRESS Marion Hawkins SAA		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Vascular Accident</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Atherosclerotic Vascular Disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Bad Riddan</i> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (d)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 months</i>
19a. DATE OF OPERATION <i>3/13, 3/15, 3/14/85</i>					
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Sacral Ulcer</i>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>3/13/85</i> 19 <i>85</i> to <i>4/19/85</i> 19 <i>85</i> , that (I) (we) last saw the deceased alive on <i>4/18/85</i> 19 <i>85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>B. Peacock</i>		DEGREE		22c. DATE SIGNED <i>4/19/85</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. B. PEACOCK MD.		22e. ADDRESS 4273 Branch Ave., Temple Hills, Md. 20748			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/ 24/ 85	23c. NAME OF CEMETERY OR CREMATORY Union Bethel CH.		23d. LOCATION CITY OR TOWN COUNTY STATE Brandywine PG Md.
24. FUNERAL DIRECTOR NAME Martell Adams Aquasco, Md.			25a. DATE REC'D. BY REGISTRAR (25b. REGISTRAR'S SIGNATURE) APR 26 1985 <i>[Signature]</i>		

MEDICAL CERTIFICATION

CHIEF IN CHARGE

FOR COLLECTION FIBEL

12294

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		ESTIMATED		MONTH		DAY		YEAR		2b. HOUR	
Arthur Francis Henderson								4-16		1985									
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
Male		White		10-10-19		65 YRS.						4-19		1985					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		WIDOWED		DIVORCED		1. BALTIMORE CITY OR COUNTY OF DEATH							
NEW YORK		U.S.A.		X								Prince Georges							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK)		12b. KIND OF BUSINESS OR INDUSTRY													
Temple Hills		7117 Temple Hill Road		RET- CARPENTER		CONSTRUCTION													
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS											
Md.		P.G.C.		TEMPLE HILLS		YES X NO		7117 TEMPLE HILL RD. 20748											
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME																	
GEORGE		MARY																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS													
YES		W.W.II		113-07-5640		LUCILLE HENDERSON		206 BOONES DR. LOTHIAN, Md. 20711											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																	
PART 1 DEATH WAS CAUSED BY:																			
IMMEDIATE CAUSE (a)																			
DUE TO, OR AS A CONSEQUENCE OF																			
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.																			
(b)																			
DUE TO, OR AS A CONSEQUENCE OF																			
(c)																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1																			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?															
				YES		NO													
21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED															
		HOUR A.M. MONTH DAY YEAR		ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2															
21d. INJURY OCCURRED WHILE AT WORK		21e. PLACE OF INJURY		21f. LOCATION															
NOT WHILE AT WORK		(AT HOME, STREET, FACTORY, FARM, ETC.)		STREET		CITY OR TOWN		COUNTY		STATE									
22a. I certify that I took charge of the remains described above, held an Autopsy		Inspection		Inquiry		and in my opinion													
death resulted from:		Natural causes		Accident		Suicide		Homicide		Undetermined manner									
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE															
Augusto P. Rodriguez		Deputy		4-19-85															
EXAMINER'S NAME		ADDRESS																	
Augusto P. Rodriguez, M.D.		5009 Rayburn Ct., Temple Hills, Md																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION													
CREMATION		4-20-1985		CHAMBERS CREMATORY		RIVERDALE, P.G.C. Md.													
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE OF REGISTRATION		25b. REGISTRAR'S SIGNATURE													
W. W. CHAMBERS CO.		RIVERDALE, Md. 20737		APR 23 1985		John Davidson-Randall													

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXCEUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE KEPT, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF PUBLIC RECORDS, 201 WESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

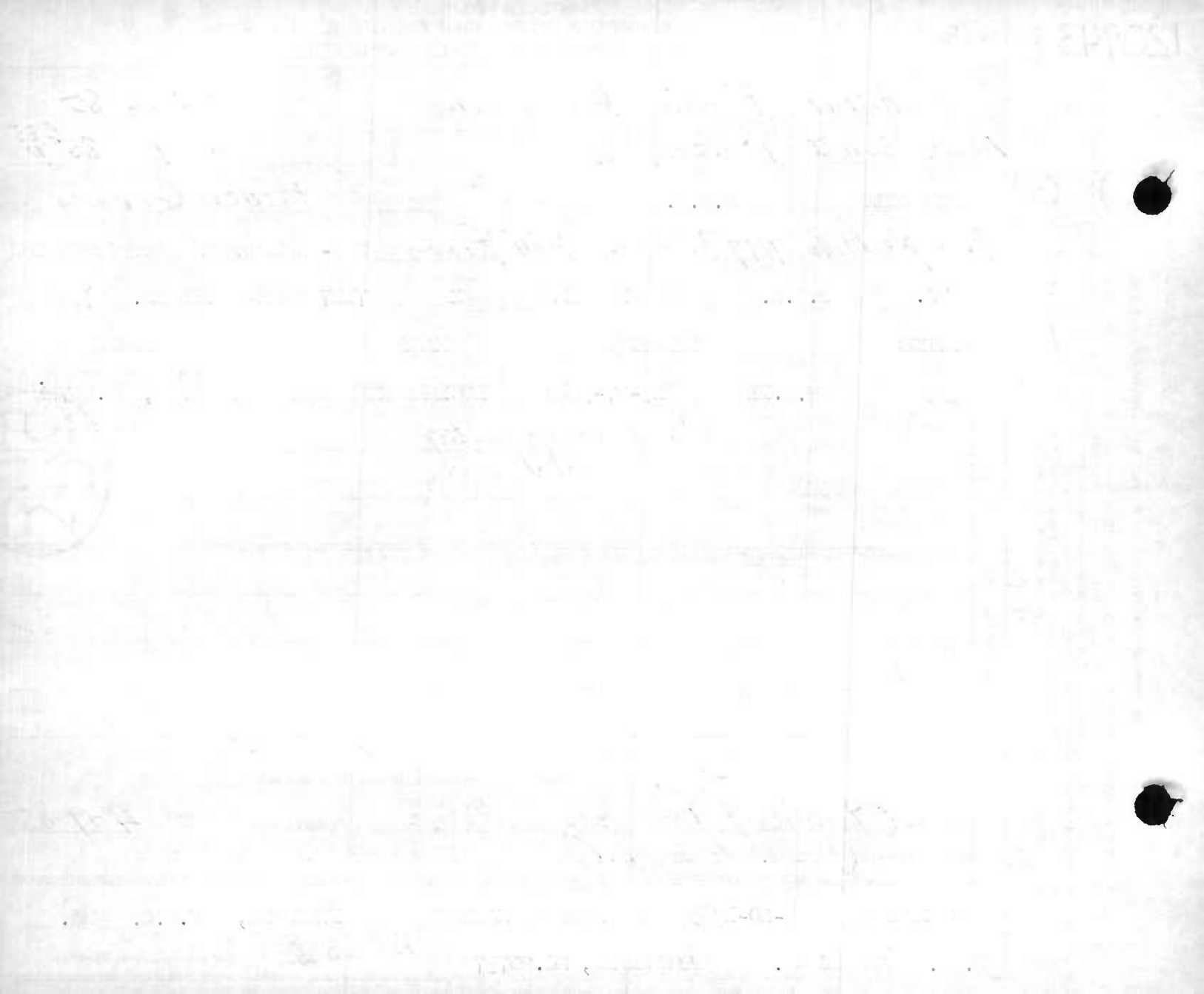
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DHMH - 17



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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) BEVERLY HERVEY					2a. DATE OF DEATH MONTH DAY YEAR 04 11 85			2b. HOUR 10 57AM	
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR Nov. 21, 1947		6. AGE (IN YEARS LAST BIRTHDAY) 37 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES COUNTY MD.			
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION PRINCE GEORGES GENERAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Computer Tech.		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY P.G. 13c. CITY OR TOWN Landover					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 7256 Landover Road 20785		
14. FATHER'S NAME FIRST MIDDLE LAST James E. Chambers					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Catherine Ann Palmer				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 577 84 0958		17. INFORMANT ADDRESS Barbara Chambers-sister-in-law-3038 Brightseat Road, Lanham, Maryland					
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (b) CARDIOGENIC SHOCK DUE TO, OR AS A CONSEQUENCE OF (c) VENTRICULAR TACHYARRHYTHMIAS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: no									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 4, 11, 1985 to 4, 11, 1985 , that (I) (we) lost saw the deceased alive on 4, 11, 1985 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE V.P. SINCH					DEGREE			22c. DATE SIGNED 4.13.85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) V.P. SINCH					22e. ADDRESS 5632 ANNAPOLIS RD #9 BLADENSBURG MD. 20710				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE April 16, 1985		23c. NAME OF CEMETERY OR CREMATORY Lincoln Memorial Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, Maryland			
24. FUNERAL DIRECTOR NAME John T. Stewart, III ADDRESS Stewart Funeral Home-4001 Benning Road, N.E.					25a. DATE REC'D. BY REGISTRAR APR 23 1985		25b. REGISTRAR'S SIGNATURE John Davidson-Randall		

BP

150074



LIBRARY
UNIVERSITY OF CALIFORNIA

10-10-58

RECEIVED

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

127011

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 1 2 2 9 6

1- FOR STATE REGISTRAR		2a DATE OF DEATH		2b HOUR	
WILLIAM F. HESSLER		04 27 85		3 15PM	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE	7b HOUR	
Male	White	7-13-1925	59 YRS.	3 15PM	
7a BIRTHPLACE	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED	9 BALTIMORE CITY OR COUNTY OF DEATH		
Wash., D.C.	U.S.A.	NEVER MARRIED	PRINCE GEORGE'S		
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION		12a USUAL OCCUPATION		
CHEVERLY	PRINCE GEORGE'S GENERAL HOSPITAL		Painter		
13a STATE		13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	
Md.	Pr. Geo.	Hy.	YES	NO	
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME		16a WAS DECEASED EVER IN U.S. ARMED FORCES?	
Bernard P. Hessler		Catharine M. Ardeeser		NO	
16b SOCIAL SECURITY NO.		17 INFORMANT		18 CAUSE OF DEATH	
579-30-4361		Catharine V. Howe		PART I. DEATH WAS CAUSED BY	
		Wash., D.C.		IMMEDIATE CAUSE (a) Cardio-respiratory arrest	
				DUE TO, OR AS A CONSEQUENCE OF	
				(b) portal hypertension, cirrhosis	
				DUE TO, OR AS A CONSEQUENCE OF	
				(c)	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
renal failure, aspiration pneumonia					
19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY?	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
		YES	NO		
21a ACCIDENT WAS UNDERLYING	21b TIME OF INJURY	21c HOW INJURY OCCURRED			
OR CONTRIBUTING	HOUR A.M. MONTH DAY YEAR	(ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)			
(IF EITHER NOTIFY MEDICAL EXAMINER)	P.M.	19			
21d INJURY OCCURRED	21e PLACE OF INJURY	21f LOCATION			
WHILE AT WORK	(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	STREET CITY OR TOWN COUNTY STATE			
NOT WHILE AT WORK					
22a I certify that (I) (this hospital) attended the deceased from 4-16, 19 85, to 4-27, 19 85, that (I) (we) last saw the deceased alive on 4-27, 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE		DEGREE		22c DATE SIGNED	
P. Thomas Lyons M.D.		ATTENDING PHYSICIAN		4-28-85	
22d PHYSICIAN'S NAME		MEDICAL DIRECTOR		STAFF PHYSICIAN	
P. Thomas Lyons					
22e ADDRESS					
23a BURIAL, CREMATION, REMOVAL	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION		
CREMATION	4-29-85	Ft. Lincoln Crematory	Brentwood Pr. Geo. Md.		
24 FUNERAL DIRECTOR		MAY 01 1985			
Nalley's F.H. Inc. Mt. Rainier, Md.		J. A. Davidson			

12-11

DATE: 12-11-11 TIME: 10:55 AM

REPORT NO. 1000000000

PROJECT NO. 1000000000

DATE: 12-11-11



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130014

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1 - STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ROBERT R. HICKERNELL			2a. DATE OF DEATH MONTH DAY YEAR 04 26 85			2b. HOUR 8 35 A	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 02 27 1917		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD.	
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION PGGH & MEDICAL CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Auto Mechanic		12b. KIND OF BUSINESS OR INDUSTRY Scanlons	
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE Maryland		13b. COUNTY P.G.		13c. CITY OR TOWN Hyattsville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Russell E. Hickernell		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Iona M. Ruble		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes - Navy W.W.II			
16b. SOCIAL SECURITY NO. 579-01-5901		17. INFORMANT ADDRESS Margaret Hickernell (Wife) Same as 13e					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) BILATERAL BRONCHIAL PNEUMONIA & MYOCARDIAL INFARCTION

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause lost.

(b) _____

(c) _____

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
CARCINOMA OF LUNG; CARCINOMA OF LARYNX SURGERY 4-18-85

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 4/16, 1985, to 4/26, 1985, that (I) (we) lost saw the deceased alive on 4/25, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Gerardo M. Gacac				DEGREE MD		22c. DATE SIGNED 4/26/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GERARDO M GACAC				22e. ADDRESS 6492 LANDOVER RD LANDOVER, MD. 20785			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 4/27/85		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria N/A Virginia	
24. FUNERAL DIRECTOR'S NAME Francis Gacac's Sons Funeral Home, P.A. 4739 Baltimore Avenue Hyattsville, Md. 20781				25a. DATE REC'D. BY REGISTRAR MAY 8 1985		25b. REGISTRAR'S SIGNATURE John Davidson-Randall	

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of case.

MEDICAL CERTIFICATION

130034



RECEIVED
MAY 19 1964

CITY

STATE OF NEW YORK

OFFICE OF THE ATTORNEY GENERAL

State

LEGISLATIVE COUNCIL

OFFICE OF THE ATTORNEY GENERAL

MAY 19 1964

119068

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR


1. DECEASED NAME (TYPE OR PRINT) Olive M. Hodgson			2a. DATE OF DEATH MONTH DAY YEAR April 12, 1985		2b. HOUR 12:45p M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR July 26, 1911		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS: HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.	
10. CITY OR TOWN OF DEATH Riverdale	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Leland Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Teacher		12b. KIND OF BUSINESS OR INDUSTRY Teaching
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.			13b. COUNTY Pr. Geo.	13c. CITY OR TOWN Mt. Rainier	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Allen Putnam			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bessie L. (Unknown)		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 579-10-4312		17. INFORMANT ADDRESS 3209-R. I. Ave. Mickie J. Hodgson Mt. Rainier, Md.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary arrest		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	DUE TO, OR AS A CONSEQUENCE OF (b) Cerebrovascular accident	9 days
	DUE TO, OR AS A CONSEQUENCE OF (c) Hypertensive cardiovascular disease	Years


PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that (I) (this hospital) attended the deceased from 19 **78** to **April 12** 19 **85**, that (I) (we) lost
saw the deceased alive on **April 11** 19 **85**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE 	DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 4-12-85
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Hong L. Tee, M.D.	22e. ADDRESS 3415 Hamilton Street, Hyattsville, Md. 20782	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 4-15-85	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.	23d. LOCATION CITY OR TOWN COUNTY STATE Suitland Pr. Geo. Md.
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24. FUNERAL DIRECTOR NAME Nalley's F.H. Inc. Mt. Rainier, Md.	25. DATE RECEIVED BY REGISTRAR APR 19 1985	26. REGISTRAR'S SIGNATURE 
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



SECTION
10

1060810

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) Ruth Louise Hood			2a DATE OF DEATH MONTH DAY YEAR April 7, 1985		2b HOUR 2:45P M	
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Sept. 12, 1911		
6 AGE (IN YEARS LAST BIRTHDAY) 73		7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b CITIZEN OF WHAT COUNTRY? U.S.A.		
8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD.				
10 CITY OR TOWN OF DEATH Cheverly		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince George's General Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		
12b KIND OF BUSINESS OR INDUSTRY Own Home		13a STREET ADDRESS / ZIP CODE 9123 Fowler Lane 20706				
14 FATHER'S NAME FIRST MIDDLE LAST Charles Ricks		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ada Johnson				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. 578-24-3610		17 INFORMANT ADDRESS Mr. Redman E. Hood		
18a STATE Maryland		18b COUNTY P.G.		18c CITY OR TOWN Lanham		
19a DATE OF OPERATION April 13, 1985		19b CONDITION FOR WHICH OPERATION WAS PERFORMED arteriosclerosis heart disease pneumonia chronic obstructive lung disease		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		
21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, FARM ETC.)		
21f LOCATION STREET CITY OR TOWN COUNTY STATE		22a I certify that (I) (this hospital) attended the deceased from April 13, 1985 to April 7, 1985 , that (I) (we) last saw the deceased alive on April 7, 1985 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b SIGNATURE Till Bergemann		DEGREE Physician		22c DATE SIGNED April 8, 1985		
22d PHYSICIAN'S NAME (TYPE OR PRINT) Till Bergemann, M.D.		22e ADDRESS 115 Centerway - Greenbelt, Maryland				
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 4-10-85		23c NAME OF CEMETERY OR CREMATORY Natl. Mem. Park Cem.		
23d LOCATION CITY OR TOWN COUNTY STATE Falls Church N/A Virginia		24 FUNERAL DIRECTOR NAME ADDRESS F. Gasch's Sons F.H. P.A. Hyattsville, Maryland				
25a DATE REC'D. BY REGISTRAR APR 11 1985		25b REGISTRAR'S SIGNATURE [Signature]				

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

10 min
6 days

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

arteriosclerosis heart disease pneumonia chronic obstructive lung disease

19a DATE OF OPERATION
19b CONDITION FOR WHICH OPERATION WAS PERFORMED
20a AUTOPSY?
YES ☐ NO ☒

21a ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)
21b TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d INJURY OCCURRED
WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e PLACE OF INJURY
(AT HOME STREET FACTORY OFFICE, FARM ETC.)
21f LOCATION
STREET CITY OR TOWN COUNTY STATE

22a I certify that (I) (this hospital) attended the deceased from **April 13, 1985** to **April 7, 1985**, that (I) (we) last saw the deceased alive on **April 7, 1985**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b SIGNATURE
Till Bergemann
DEGREE
Physician
22c DATE SIGNED
April 8, 1985

22d PHYSICIAN'S NAME (TYPE OR PRINT)
Till Bergemann, M.D.
22e ADDRESS
115 Centerway - Greenbelt, Maryland

23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 4-10-85		23c NAME OF CEMETERY OR CREMATORY Natl. Mem. Park Cem.		23d LOCATION CITY OR TOWN COUNTY STATE Falls Church N/A Virginia	
24 FUNERAL DIRECTOR NAME ADDRESS F. Gasch's Sons F.H. P.A. Hyattsville, Maryland				25a DATE REC'D. BY REGISTRAR APR 11 1985			
25b REGISTRAR'S SIGNATURE [Signature]							

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
Henry Charles Houck

2a. DATE OF DEATH MONTH DAY YEAR
April 22, 1985

2b. HOUR
10:10 P.M.

3. SEX
Male

4. RACE
Caucasian

5. DATE OF BIRTH MONTH DAY YEAR
Feb. 9, 1903

6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS
82

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland

7b. CITIZEN OF WHAT COUNTRY?
USA

8. MARRIED ☒ NEVER MARRIED ☐
WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH
Prince Georges MD.

10. CITY OR TOWN OF DEATH
Bowie

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
2512 Knighthill Lane

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired

12b. KIND OF BUSINESS OR INDUSTRY
Policeman

13a. STATE
Maryland

13b. COUNTY
Prince Georges

13c. CITY OR TOWN
Bowie

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE
2512 Knighthill Lane 20715

14. FATHER'S NAME FIRST MIDDLE LAST
Harry Albert Houck

15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Teresa Regina Walsh

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
no

16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)

17. INFORMANT ADDRESS
Marie F. Houck same as 13e

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PULMONARY EDEMA 2 DAYS

CONGESTIVE HEART FAILURE 1 YEAR

ADENOCARCINOMA SIGMOID 4 MONTHS

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.

MEDICAL CERTIFICATION

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE ☐ AT WORK ☐ NOT WHILE ☐ AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from **Nov. 76**, 19 **76**, to **4-22**, 19 **85**, that (I) (we) last saw the deceased alive on **4-22-85**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE
John Cosma M.D. DEGREE

ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED
Apr. 23, 1985

22d. PHYSICIAN'S NAME (TYPE OR PRINT)
JOHN COSMA M.D.

22e. ADDRESS
14300 GALLANT FOX, BOWIE, MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial

23b. DATE
April 25, 1985

23c. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln Cemetery

23d. LOCATION CITY OR TOWN COUNTY STATE
Brentwood, Prince George's, MD

24. FUNERAL DIRECTOR NAME
Beall Funeral Home

25a. DATE REC'D. BY REGISTRAR
APR 29 1985

25b. REGISTRAR'S SIGNATURE
Lelia Davidson-Randall

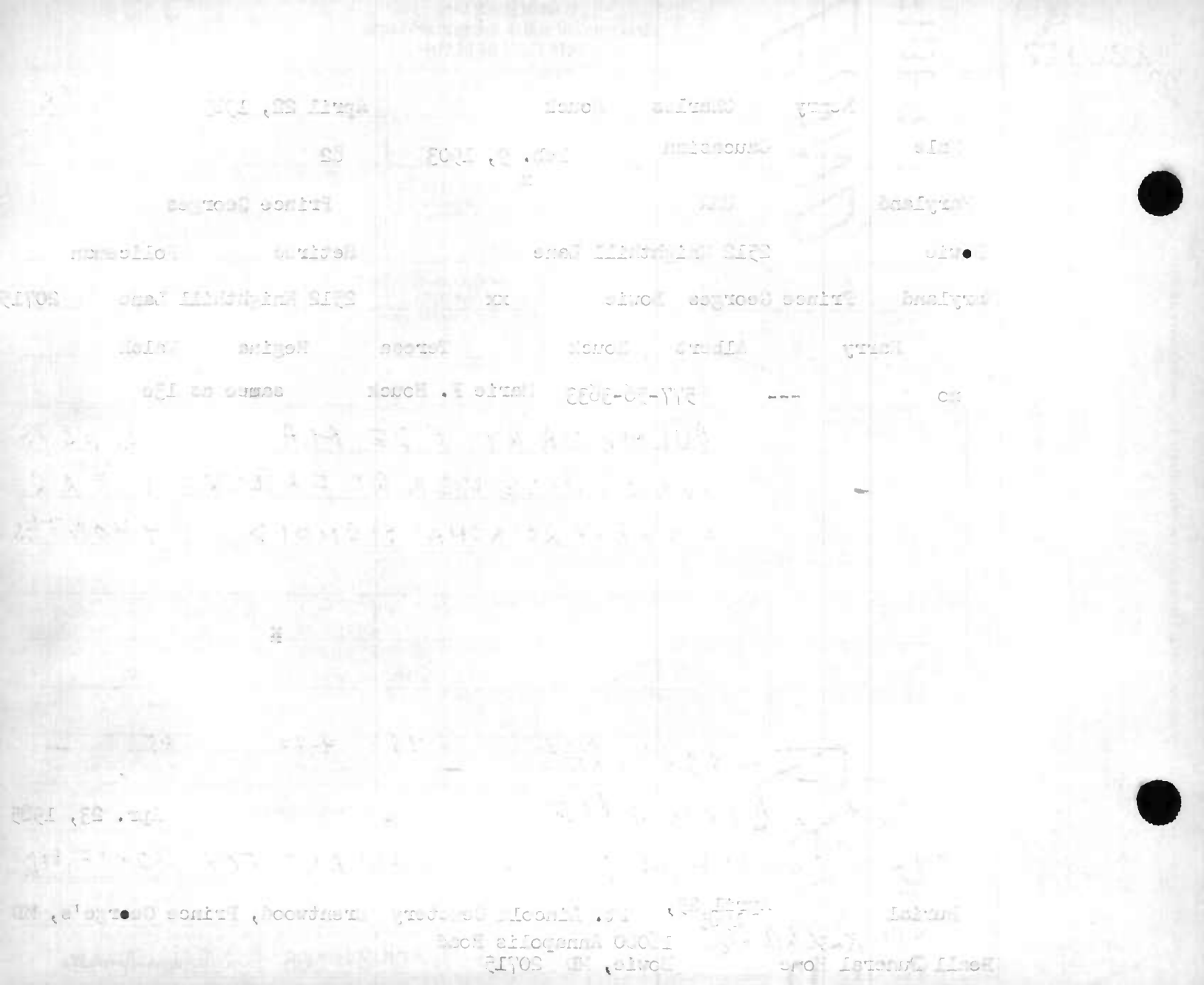
BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with a 24-hour after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

122047



DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

BP_____

DHMH - 17
(VR A15 ME (5))
20M 4/B2



DHMH - 17
(VR A15 AE (5))

20M 4/B2

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST Mae		MIDDLE Owens		LAST Hughes		2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> MONTH DAY YEAR 4/30 19 85		2b. HOUR 7:45	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sep. 3, 1904		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.		IF UNDER 1 YR. MONTHS DAYS 26 45		IF UNDER 24 HRS. HOURS MIN 26 45	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD					
10. CITY OR TOWN OF DEATH Columbia Park		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1609 Columbia Avenue				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Supply Buyer		12b. KIND OF BUSINESS OR INDUSTRY Coal Co.			
13a. STATE Maryland		13b. COUNTY Prince George's		13c. CITY OR TOWN Columbia Park		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1609 Columbia Avenue 20785			
14. FATHER'S NAME FIRST MIDDLE LAST Sherrwood Owens				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Josephine Catherine Johnson							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE YEAR OR DATES) NO N/A		16b. SOCIAL SECURITY NO. 236-22-1189		17. INFORMANT (Daughter) ADDRESS Elizabeth H. Poole, Same as Line #13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial disease. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a. None											
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) None							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE 		TITLE (SPECIFY) M.D. Deputy		MEDICAL EXAMINER 1919 Seminary Road				DATE SIGNED 4/30/85			
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, M.D.		ADDRESS Silver Spring, Montgomery, Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5-4-1985		23c. NAME OF CEMETERY OR CREMATORY Monte Vista Park Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Princeton, Mercer, W. Va.			
24. Francis Casch's Sons Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, Maryland						25a. DATE REC'D. BY REGISTRAR MAY 8 1985		25b. REGISTRAR'S SIGNATURE 			

130010



Yours	White	Rep. 7, 1914	80	Queen	Hubert	85
Columbia Park 1009 Columbia Avenue						
Maryland Prince George's Columbia Park 1009 Columbia Avenue						

acute myocardial disease.

None

None

None

X

X

130010

John E. Brown, M.D.
 Silver Spring, Maryland, Md.
 1919 Secretary Genl.

105144

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 2 3 0 2

1. DECEASED NAME (TYPE OR PRINT) RUBY B HUNTT			2a. DATE OF DEATH MONTH DAY YEAR 04 01 85		2b. HOUR 7:00 PM
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR August 29, 1911		6. AGE (IN YEARS LAST BIRTHDAY) 73	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S		
10. CITY OR TOWN OF DEATH CLINTON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Md Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sales Clerk	12b. KIND OF BUSINESS OR INDUSTRY Retail Sales	
13a. STATE Maryland		13b. COUNTY Prince George's	13c. CITY OR TOWN Clinton	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 3410 Delancy Street (20735)
14. FATHER'S NAME FIRST MIDDLE LAST Charles H. Board			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Georgetta Shaver		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT ADDRESS Thelma W. Smith - Same As #13 A-E	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiogenic shock DUE TO, OR AS A CONSEQUENCE OF (b) acute myocardial infarct DUE TO, OR AS A CONSEQUENCE OF (c) congestive heart failure					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: double malts					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 3-30 19 85 , to 4-1 19 85 , that (I) (we) last saw the deceased alive on 4-1 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) see the body after death.					
22b. SIGNATURE Robert V. Vickersky MD			DEGREE MD		22c. DATE SIGNED 4-1-85
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert V. Vickersky MD			22e. ADDRESS 5711 ACENTOWN Rd. Suitland Md		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE April 5, 1985		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, Maryland		24. FUNERAL DIRECTOR NAME ADDRESS Lee Funeral Home, Inc. 6633 Old Alexander Ferry Road, Clinton, Maryland			
25a. DATE REC'D. BY REGISTRAR APR 9 1985		25b. REGISTRAR'S SIGNATURE Richard Anderson-Randall			

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MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

6633

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

10514



WELDON
COLLECTION
LIBRARY
22-1-A

Handwritten text, possibly a signature or name, appearing as "William" and "H. H. H."

Handwritten signature or name, possibly "J. H. H."

113080

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) George William Husker			2a. DATE OF DEATH MONTH DAY YEAR April 12, 1985			2b. HOUR 3 P.M.				
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH 09 TH 02 1902		6. AGE (IN YEARS LAST BIRTHDAY) 82		7. IF UNDER 1 YEAR MONTHS DAYS		
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Connecticut		9. CITIZEN OF WHAT COUNTRY? U.S.A.		10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH Prince George MD.				
12. CITY OR TOWN OF DEATH Riverdale		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6004 Norman Avenue				14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Office Manager		15. 12b. KIND OF BUSINESS OR INDUSTRY Sloane Insurance		
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY P.G.		13c. CITY OR TOWN Riverdale		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 6004 Norman Avenue 20737	
14. FATHER'S NAME George S. Husker			15. MOTHER'S MAIDEN NAME Elizabeth M. Crossland							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NAME AND UNKNOWN) Yes			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWI & WWII 136-01-1412		17. INFORMANT ADDRESS Christopher R. Husker (Son) Same as 13e					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Squamous Cell Carcinoma Lung</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Parkinson's Disease</u>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22. I certify that (I) (XXXXXX) attended the deceased from 10-17 19 84 to 4-11- 19 85, that (I) (X) last saw the deceased alive on 4-11- 19 85 and that in (my) (X) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
23. SIGNATURE <u>Stuart I. Turkewitz</u> M.D.						DEGREE M.D.		24. DATE SIGNED 4-13-85		
25. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Stuart I. Turkewitz, M.D.						26. ADDRESS 7500 Greenway Center, Greenbelt, Md. 20770				
27a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			27b. DATE 4/13/85		27c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory Alexandria			27d. LOCATION CITY OR TOWN COUNTY STATE Virginia		
28. FUNERAL DIRECTOR NAME Francis Gasch's Sons Funeral Home						29. DATE REC'D. BY REGISTRAR APR 18 1985		30. REGISTRAR'S SIGNATURE <u>Williamson Hande</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

000000

PONY COTTON & PELS

WELLS BOW



1

113125

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETURN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL. TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (1))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF DEATH			MONTH DAY YEAR			2b. HOUR		
Lillian			B.			Hyman			4/12 19 85			1:30 A. M.		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD			MONTH DAY YEAR			2d. HOUR		
Female	White	Sep. 15, 1896	88 YRS.			4/12 19 85						1:30 A. M.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH					
TEXAS			U.S.A.						Prince George's County MD.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Adelphi			8613 - 20th Avenue			HOUSEWIFE			OWN HOME					
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)														
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS		
Maryland			Prince George's			Adelphi			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			8613 - 20th Avenue		
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME									
FIRST MIDDLE LAST					FIRST MIDDLE LAST									
RABBI LOUIS					HIRSCH					ANNA LEVINE				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)					16b. SOCIAL SECURITY NO.					17. INFORMANT				
NO					347-03-4518					MAXINE H. LUTZ, 8613 20th AVENUE, ADELPHI, MARYLAND				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)														
PART I DEATH WAS CAUSED BY:														
IMMEDIATE CAUSE (a) <u>Acute myocardial disease</u>														
DUE TO, OR AS A CONSEQUENCE OF														
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.														
(b) <u>generalized arteriosclerosis.</u>														
DUE TO, OR AS A CONSEQUENCE OF														
(c)														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1														
None														
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY?				
None										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH					21b. TIME OF INJURY					21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
					HOUR A.M. MONTH DAY YEAR									
					P.M. 19					None				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)					21f. LOCATION				
										STREET CITY OR TOWN COUNTY STATE				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .														
ACTUAL SIGNATURE					TITLE (SPECIFY)					DATE SIGNED				
					M.D. Deputy					4/12/85				
EXAMINER'S NAME (TYPE OR PRINT)					ADDRESS									
John S. Rogers, M.D.					1919 Seminary Road									
					Silver Spring, Montgomery, Md.									
23a. BURIAL, CREMATION, REMOVAL					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY				
BURIAL					4/15/1985					MOUNT LEBANON CEMETERY				
										23d. LOCATION				
										ADELPHI, PRINCE GEORGE'S, MARYLAND				
24. FUNERAL DIRECTOR														
DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME														
232 CARROLL STREET, N. W., WASHINGTON, D. C.														
25a. DATE REC'D. BY REGISTRAR														
APR 17 1985														
25b. REGISTRAR'S SIGNATURE														

Prince George's County

8013 - 200 Avenue

Prince George's - Adelphi

8013 - 200 Avenue

Acute myocardial infarction

Generalized arteriosclerosis

None

None

None

John S. Rogers, M.D.

1000 Boundary Road

Silver Spring, Montgomery, Md.

127006

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1 2 3 0 5

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST SAMUEL		MIDDLE F.		LAST INDOLFI		2a. DATE KNOWN OF DEATH		X MONTH DAY YEAR 4 26 1985		2b. HOUR M 745 A M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Oct. 11, 1938		6. AGE (IN YEARS) (LAST BIRTHDAY) 46 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 4 26 1985	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George MD							
10. CITY OR TOWN OF DEATH Fort Washington		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3015 Alderton Avenue Alderton Ave.						12a. USUAL OCCUPATION (TYPE OF WORK OR INDUSTRY) Office Secy. Defense		12b. KIND OF BUSINESS OR INDUSTRY Fed. Gov.			
13a. STATE Maryland		13b. COUNTY Prince George		13c. CITY OR TOWN Fort Washington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3015 Alderton Ave. 20744					
14. FATHER'S NAME FIRST MIDDLE LAST Ralph A. Indolfi				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Florence Lupis				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No					
				16b. SOCIAL SECURITY NO. 219-34-7211		17. INFORMANT ADDRESS Mother Mrs. Florence Indolfi, Frederick, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 <u>Lupus Erythematosus</u>													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE <u>Augusto P. Rodriguez</u>				TITLE (SPECIFY) M.D. Deputy				MEDICAL EXAMINER				DATE SIGNED 4/26/1985	
EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez, M.D.				ADDRESS 5009 Rayburn Ct., Temple Hills, Md									
23a. BURIAL, CREMATION, REMOVAL Burial				23b. DATE 4-29-1985		23c. NAME OF CEMETERY OR CREMATORY SS. Peter & Paul Cem.				23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland, Allegany, Md.			
24. FUNERAL DIRECTOR NAME James F. Scarpelli				ADDRESS Cumberland, Md. 21502				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE MAY 01 1985	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGE 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP

DHMH - 17
(VR A15 ME (5))

119113

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ANNE PLUMLEY IVERSON			2a. DATE OF DEATH MONTH DAY YEAR 4/23/85		2b. HOUR 8:30A M	
3 SEX Female		4 RACE Caucasian		5 DATE OF BIRTH MONTH DAY YEAR March 3 1900		6 AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. 85 YRS
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
9a BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		9b CITIZEN OF WHAT COUNTRY? U.S.A.		9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES COUNTY MD.		
10 CITY OR TOWN OF DEATH CLINTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTHERN MARYLAND HOSPITAL		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Chief Fire Section		12b KIND OF BUSINESS OR INDUSTRY Maritime Comm.
13a USUAL RESIDENCE (# NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Maryland Prince Georges Oxon Hill		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 1515 Ferguson Lane 20744		
14 FATHER'S NAME FIRST MIDDLE LAST Milas Wallas Thompson		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Orpha Roberts				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b SOCIAL SECURITY NO. 579-16-7324		17 INFORMANT ADDRESS Peg Greenway 1515 Ferguson Lane Oxon Hill, Md.		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Metastatic Colonic Carcinoma DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 1/2 yrs
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Coronary Artery disease, carotid stenosis, old stroke						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE		
22a. I certify that (1) this hospital attended the deceased from March 8, 1985 to April 23, 1985 that (2) (we) last saw the deceased alive on Apr 22, 1985 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death.)						
22b. SIGNATURE Ronald L. Landman MD		DEGREE		MEDICAL ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/23/85
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Ronald L. Landman MD		22e. ADDRESS 9440 Pennsylvania Ave. Upper Marlboro, Md.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/26/85		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland P.G. Maryland
24. FUNERAL DIRECTOR NAME George P. Kalas Funeral Home		6160 Oxon Hill Rd. Oxon Hill, Md.		25a. DATE REC'D. BY REGISTRAR APR 25 1985		25b. REGISTRAR'S SIGNATURE John Davidson

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

11-11-40

RECEIVED

March 2 1940

Canadian

Canada

U.S.A.

United States

United States Customs Service

1939-40

1939-40

Exports

Imports

Transit

Re-Exports

Re-Imports

1939-40

1939-40

March 2 1940

CANADA

Canada

U.S.A.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Rosabella Monroe JACKSON			2a DATE OF DEATH MONTH DAY YEAR April 12, 1985		2b HOUR 9:24P _M
3 SEX Female	4 RACE Black	5 DATE OF BIRTH MONTH DAY YEAR Aug. 24, 1914		6 AGE (IN YEARS LAST BIRTHDAY) 70 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash., D.C.	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.	
10 CITY OR TOWN OF DEATH Lanham	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Doctors' Hospital of Pr. Geo. Co.		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired	12b KIND OF BUSINESS OR INDUSTRY	
13a STATE Maryland			13b COUNTY PG	13c CITY OR TOWN Greenbelt	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
14 FATHER'S NAME FIRST MIDDLE LAST Lewis Monroe			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jenny Steptoe		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b SOCIAL SECURITY NO. 579 09 6244		17 INFORMANT ADDRESS 7716-301 Hanover Parkway-Greenbelt, Md.	

18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☒20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐
AT WORK AT HOME

21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)21f. LOCATION
STREET CITY OR TOWN COUNTY STATE

22a. I certify that (1) this hospital attended the deceased from 4/11/85, 1985, to 4/12/85, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, we will so indicate on the body after death.)

22b. SIGNATURE

DEGREE

ATTENDING
PHYSICIANMEDICAL
DIRECTORSTAFF
PHYSICIAN

22c. DATE SIGNED

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

22e. ADDRESS

Lewis H. Dennis M. D.

831 Univ. Blvd. E., Silver Spring, Md. 20903

23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial

23b. DATE

April 18, 1985

23c. NAME OF CEMETERY OR CREMATORY

Harmony Memorial Park Landover, Md.

23d. LOCATION
CITY OR TOWN COUNTY STATE

24. FUNERAL DIRECTOR

NAME

Stewart

John T. Stewart, III

Funeral Home-4001 Benning Road, N.E.

25a. DATE REC'D. BY REGISTRAR

APR 23 1985

25b. REGISTRAR'S SIGNATURE

[Signature]

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

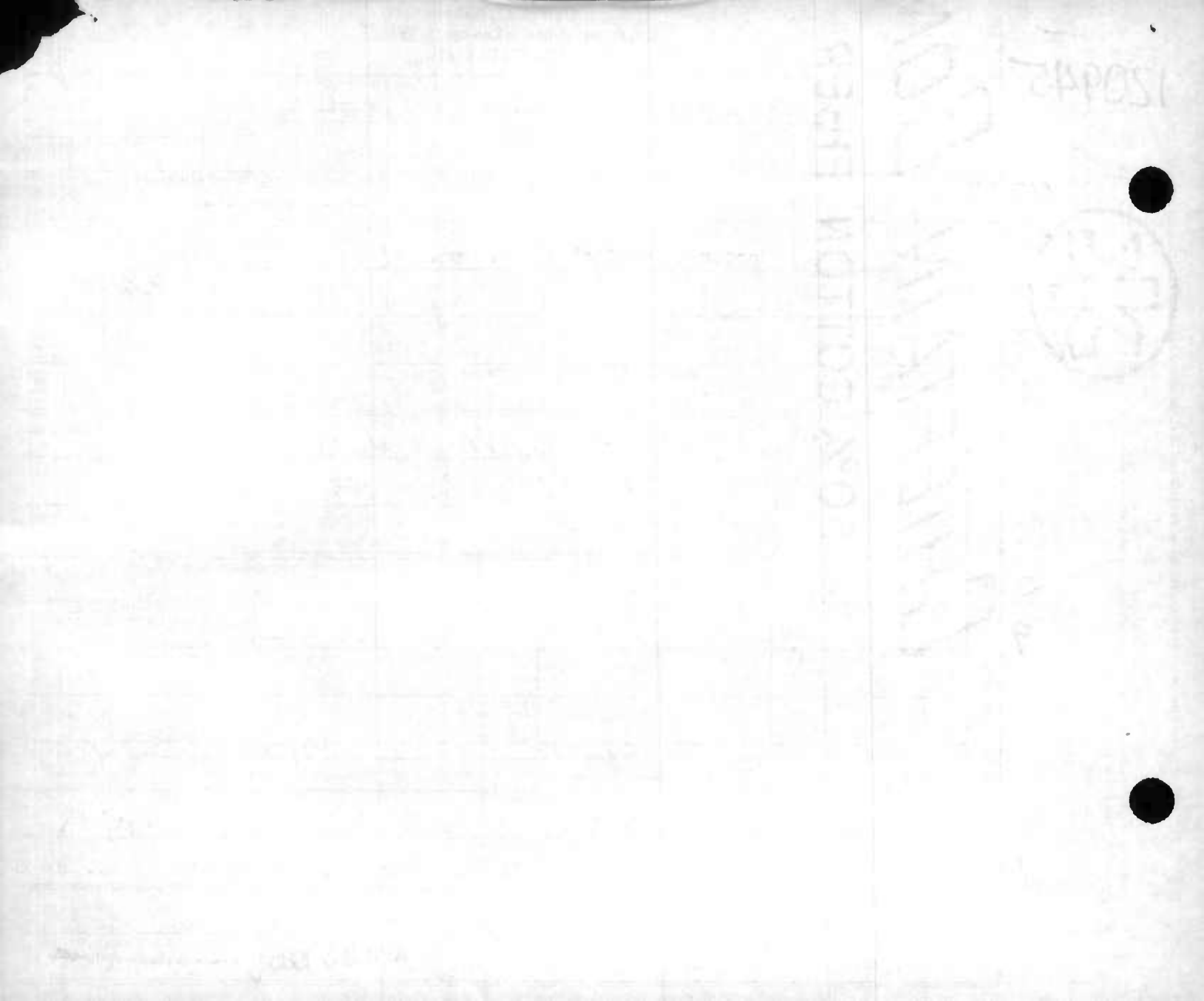
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CONJUNCTION LINE

NO. 1000

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 1 2 3 0 8	
1- FOR STATE REGISTRAR										7a. DATE KNOWN OF DEATH	
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Robert F. James, Jr.										ESTIMATED MONTH DAY YEAR April 17 1985	
3 SEX Male	4 RACE White	5. DATE OF BIRTH MONTH DAY YEAR May 22, 1915	6. AGE (IN YEARS) (LAST BIRTHDAY) 69	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD April 19 1985		2b. DATE KNOWN OF DEATH			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD.					
10. CITY OR TOWN OF DEATH Laurel		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greater Laurel Beltsville Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Heavy Equip. Operator		12b. KIND OF BUSINESS OR INDUSTRY Sand & Gravel Co.			
13a. STATE Maryland										13b. COUNTY P.G.	
13c. CITY OR TOWN Laurel										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS Rt. # 2 - 137A 20707											
14. FATHER'S NAME FIRST MIDDLE LAST Robert F. James, Sr.										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Martha Bland	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes-Army W.W.II										16b. SOCIAL SECURITY NO. 216-05-7770	
17. INFORMANT Mrs. Ruth E. James										ADDRESS Address Same as No# 13e.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Div DUE TO, OR AS A CONSEQUENCE OF, Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) Chronic Myocardial Div DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. No											
19a. DATE OF OPERATION None										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE John S. Rogers, M.D.										TITLE (SPECIFY) M.D. Depr MEDICAL EXAMINER	
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, M.D.										DATE SIGNED April 17 1985	
ADDRESS 1919 Seminary Rd. Sil. Spg. Maryland											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial										23b. DATE Apr. 22, 1985	
23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery										23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood P.G. Maryland	
24. FUNERAL DIRECTOR NAME F. Gasch's Sons F.H. P.A. Hyattsville, Maryland										25a. DATE REC'D. BY REGISTRAR APR 23 1985	
25b. REGISTRAR'S SIGNATURE											

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST JOHN			MIDDLE JENKINS			LAST JENKINS			2a. DATE KNOWN OF DEATH ESTIMATED		MONTH 4		DAY 15		YEAR 19 85		2b. HOUR M	
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 1/21/46		6. AGE (IN YEARS LAST BIRTHDAY) 39 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 4 15 19 85		2d. HOUR 9:30 PM							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD									
10. CITY OR TOWN OF DEATH Cheverly				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince George's Gen. Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) Truck Driver				12b. KIND OF BUSINESS OR INDUSTRY None									
13a. STATE DC				13b. COUNTY Washington				13c. CITY OR TOWN Washington				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS 3300 Stanton Road S.E. DC					
14. FATHER'S NAME FIRST MIDDLE LAST John F. Jenkins						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eleanor Jenkins/11914 Elmwood Dr															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217 444 684				17. INFORMANT ADDRESS Eleanor Jenkins/11914 Elmwood Dr													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Narcotism</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1																					
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																					
ACTUAL SIGNATURE <i>Ann M. Dixon</i>				TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER										DATE SIGNED 4-16-85							
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.				ADDRESS 111 Penn St., Balto., MD 21201																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE Apr/20/85				23c. NAME OF CEMETERY OR CREMATORY Wash Nat				23d. LOCATION CITY OR TOWN COUNTY STATE Suitland Maryland									
24. FUNERAL DIRECTOR Dudley, S Fun Home Inc 1425 Md Ave NE												25a. DATE REC'D. BY REGISTRAR APR 22 1985		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson</i>							

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, RE-EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED. WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

126055

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1 2 3 1 0

1. DECEASED NAME (TYPE OR PRINT) <i>Melvin</i>		2a. DATE KNOWN OF DEATH ESTIMATED <i>4-27-85</i>		2b. HOUR <i>PM</i>	
3. SEX <i>Male</i>	4. RACE <i>Black</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>April 29, 1924</i>	6. AGE (IN YEARS) LAST BIRTHDAY <i>60</i> YRS	7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <i>4-28-85</i>
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>D.C.</i>		9. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
11. CITY OR TOWN OF DEATH <i>Capt. Hgts.</i>		12. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SURVEILLANCE, GIVE STREET ADDRESS) <i>5911 Burgundy Street</i>		13. BALTIMORE CITY OR COUNTY OF DEATH <i>Prince George's</i> MD	
14. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 14a. STATE <i>Md.</i> 14b. COUNTY <i>P.G.</i> 14c. CITY OR TOWN <i>Cap. Hgts.</i>		15. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		16. STREET ADDRESS <i>5911 Burgundy St.</i>	
17. FATHER'S NAME FIRST MIDDLE LAST <i>Abraham Johnson</i>		18. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Virgie Joshaway</i>		19. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>Yes WW II</i>	
20. SOCIAL SECURITY NO. <i>579-22-0232</i>		21. INFORMANT <i>Carolyn O. Johnson-Same as # 13</i>		22. ADDRESS	
23. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Diabetic cardiomyopathic cardiovascular disease</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					
24. PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I <i>Chronic obstructive pulmonary disease</i>					
25. DATE OF OPERATION		26. CONDITION FOR WHICH OPERATION WAS PERFORMED?		27. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
28. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		29. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		30. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
31. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		32. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		33. LOCATION STREET CITY OR TOWN COUNTY STATE	
34. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
35. ACTUAL SIGNATURE <i>Augusto P. Rodriguez</i>		36. TITLE (SPECIFY) <i>M.D. Deputy</i>		37. MEDICAL EXAMINER DATE SIGNED <i>4-29-85</i>	
38. EXAMINER'S NAME (TYPE OR PRINT) <i>Augusto P. Rodriguez, M.D.</i>		39. ADDRESS <i>5005 Rayburn Ct. Camp Springs, Md.</i>		40. BALTIMORE CITY OR COUNTY OF DEATH <i>20748</i>	
41. BURIAL, CREMATION, REMOVAL		42. DATE <i>5/3/85</i>		43. NAME OF CEMETERY OR CREMATORY <i>ARLINGTON NAT'L. CEM.</i>	
44. LOCATION CITY OR TOWN COUNTY STATE <i>FT. MYER, VA.</i>		45. FUNERAL DIRECTOR NAME <i>H.S. WASHINGTON + SONS</i> ADDRESS <i>4925 BURROUGHS AVE. ALEXANDRIA, VA.</i>		46. DATE REC'D. BY REGISTRAR <i>MAY 1 1985</i>	
47. REGISTRAR'S SIGNATURE		48. REGISTRAR'S SIGNATURE			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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В. В. Давыдов - кандидат физико-математических наук, доцент, профессор кафедры физики, Самарский государственный университет.

126081

FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Merle Lee Johnson			2a. DATE OF DEATH MONTH DAY YEAR 04-27-85		2b. HOUR 10:15 AM	
3. SEX Male	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR 04-04-25		6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON, D.C.		7b. CITIZEN OF WHAT COUNTRY? USA		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD		
10. CITY OR TOWN OF DEATH Riverdale		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Eugene Leland Mem. Hosp		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bookbinder		
13a. STATE MD		13b. COUNTY P.G.		13c. CITY OR TOWN Hyattsville		
14. FATHER'S NAME FIRST MIDDLE LAST JAMES R.C. JOHNSON		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EVA UNKNOWN		13d. STREET ADDRESS / ZIP CODE 5803 33rd Ave. Hyatts, Md. 20782		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. 578-24-7685		17. INFORMANT ADDRESS LARRY L. JOHNSON (SON) 6507 CARRIE LYNN CR. MT. AIRY, MARYLAND		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF LUNG DUE TO, OR AS A CONSEQUENCE OF (b) ACUTE PULMONARY EDEMA DUE TO, OR AS A CONSEQUENCE OF (c) CORONARY ARTERY DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) ATRIAL FIBRILLATION						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 4.19.85 to 4.27.85 , that (I) (we) lost saw the deceased alive on 4.26.85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE V.P. Singh		DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4.27.85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) V.P. SINGH		22e. ADDRESS 5632 ANNAPOLIS RD #9 BLADENSBURG MD 2071-				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE MAY 1, 1985		23c. NAME OF CEMETERY OR CREMATORY GEORGE WASHINGTON Cemetery		
24. FUNERAL DIRECTOR NAME CHAMBERS FUNERAL HOME		ADDRESS RIVERDALE, MARYLAND		25a. DATE REC'D. BY REGISTRAR MAY 1 1985		
		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>				

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed with in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DEATH IS SUSPECTED, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM-3. RETAIN PAGES 1, 2, AND 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 1 2 3 1 2	
1. DECEASED NAME (TYPE OR PRINT) Michael Arnell Johnson							2a. DATE KNOWN OF DEATH April 29 1985		2b. HOUR 1:54		
3. SEX M	4. RACE BLK	5. DATE OF BIRTH Oct. 19 53	6. AGE (IN YEARS) 31	7. IF UNDER 1 YR. MONTHS 0 DAYS 0	8. IF UNDER 24 HRS. HOURS 0 MIN 0	2c. DATE PRONOUNCED DEAD April 29 1985		2d. HOUR 1:54			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash., D.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD					
10. CITY OR TOWN OF DEATH Bowie		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 12154 Long Ridge Lane				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) unemployed		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Md.				13b. CITY OR TOWN Prince Georges		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 12154 Long Ridge Lane			
14. FATHER'S NAME Basil Johnson				15. MOTHER'S MAIDEN NAME Vera Brooks							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no				16b. SOCIAL SECURITY NO. 214 60 7193		17. INFORMANT Vera Johnson-mother					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Dis. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Chronic Myocardial Dis. DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) None											
19a. DATE OF OPERATION None				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE [Signature]				TITLE (SPECIFY) M.D. Dep.				DATE SIGNED April 29 1985			
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE May 4 1985		23c. NAME OF CEMETERY OR CREMATORY Ascension Catholic Church		23d. LOCATION CITY OR TOWN Bowie COUNTY Maryland STATE					
24. FUNERAL DIRECTOR NAME John T. Stewart				ADDRESS Funeral Home-4001 Benning Road, N		DATE REC'D. BY REGISTRAR MAY 1 1985		25b. REGISTRAR'S SIGNATURE [Signature]			

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DHMH - 17
(VR A15 ME (5))

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE KNOWN OF DEATH			2b. HOUR		
TAMMY RENEE JOHNSON			4 21 19 85			M		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD	7d. HOUR	
Female	Black	June 7, 1965	19 YRS.			4 21 19 85	3:35A	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		
Washington, D.C.		United States				Prince George's County, MD		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Clinton		Southern Maryland Hospital				NONE		N/A
13a. STATE			13b. CITY OR TOWN	13c. INSIDE CITY LIMITS?	13e. STREET ADDRESS			
Maryland			Nanjemoy	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	Box 41A Nanjemoy, Md. 20662			
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME		16. SOCIAL SECURITY NO.			
Harry W. Johnson			Madeline Mary Dent		217-88-9497			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
No			N/A		Harry W. Johnson - Box 41A Nanjemoy, Md. 20662			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY: 8121 IMMEDIATE CAUSE (a) Multiple injuries DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?	
							YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
			2:27xx 4 21 19 85		Passenger in auto/auto impact			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY			
			road		Indian Head Hwy & Livingston Rd, Accokeek, PG			
22a. I certify that I took charge of the remains described above, held on death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion								
ACTUAL SIGNATURE			TITLE (SPECIFY)				DATE SIGNED	
Thomas D. Smith			M.D. Acting Chief				4/21/85	
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS					
Thomas D. Smith, M.D.			111 Penn St. Balto. MD.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial			April 25, 85		Mt. Hope Church Cem.		Ironsides Charles Md.	
24. FUNERAL DIRECTOR NAME			ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Thornton's Funeral Home			Pomomkey, Md. 20640		APR 25 1985		Julia Davidson-Randall	

07/84
25M
BP
DHMH - 17
(VR A15 ME (5))

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 4 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE VITAL RECORDS, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	4 11 85			4 ²⁵ P.M.
THOMAS A. JOHNSON		3. SEX		4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
Male		White		08 01 08		76 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		
New Jersey		U.S.A.				Prince George's County, MD.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Riverdale		Leland Memorial Hospital		ELECTRICAL TECH.		ELECTRICAL		
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		
MD		MONT.		TAKOMA PARK		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		13e. STREET ADDRESS / ZIP CODE				
FIRST MIDDLE LAST NILS JOHNSON		FIRST MIDDLE LAST ALINA DANIELSEN		8113 CARROLL AVE. 20912				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS		
NO		078-07-7605		MARION O. JOHNSON		8113 CARROLL AVE T.P.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMATOSIS</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CANCER OF PROSTATE</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>UNKNOWN</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 MONTHS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>OLD STROKE</u>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>3/10</u> 19 <u>85</u> , to <u>4/11</u> 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>4/11</u> 19 <u>85</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <u>Gerald A Reinshagen</u>		DEGREE MD		22c. DATE SIGNED 4/11/85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS						
JERALS A REINSHAGEN, M.D.		5600 54th AVE. RIVERDALE MD						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		
BURIAL		APRIL 15, 1985		EAST MANCHESTER CEMETERY		Manchestre COGN STATE		
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
TAKOMA FUNERAL HOME, J. G. GRIFFIN, JR.		APR 15 1985		MARION O. JOHNSON				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

NO. 10718
DATE: 10/10/10
TO: THE CHIEF OF POLICE
FROM: DANIEL J. DANIELSON
SUBJECT: [illegible]

RE: [illegible]
[illegible]
[illegible]

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201
To release for the Baltimore, Maryland, Department of Health and Mental Hygiene
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST VICTORINE MARIE JOHNSON			2a. DATE OF DEATH MONTH DAY YEAR 4 19 85		2b. HOUR 9.30am
3 SEX FEMALE	4. RACE BLACK	5. DATE OF BIRTH MONTH DAY YEAR MAY 23, 1929		6 AGE (IN YEARS LAST BIRTHDAY) 55 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? UNITED STATES	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES COUNTY MD.	
10. CITY OR TOWN OF DEATH CLINTON MD.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTHERN MARYLAND HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CUSTODIAN		12b. KIND OF BUSINESS OR INDUSTRY PRIVATE
13a. STATE MARYLAND		13b. COUNTY CHARLES	13c. CITY OR TOWN LA PLATA	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST BENEDICT JOHNSON		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST IRENE LYLES		13e. STREET ADDRESS / ZIP CODE P.O. BOX 803 LA PLATA, MD. 20646	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17 INFORMANT ADDRESS LINDA JOHNSON 4102 Sapienza Ct. Ft. Wash. MD. 20744	

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost

DUE TO, OR AS A CONSEQUENCE OF (b) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 6/84, 19, to 4/19/85, 19, that (I) (we) lost saw the deceased alive on 4/19/85, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE R. Space MD		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 4/28/85
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. Space		22e. ADDRESS PO BOX 1558 Waldorf Md 20601	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE April 23, 1985	23c. NAME OF CEMETERY OR CREMATORY St. Mary's Ch. Cem.	23d. LOCATION CITY OR TOWN COUNTY STATE BRYANTOWN CHARLES MD.
24 FUNERAL DIRECTOR NAME THORNTON'S FUNERAL HOME		25a. DATE REC'D. BY REGISTRAR APR 25 1985	
ADDRESS POMONKEY, MD		25b. REGISTRAR'S SIGNATURE John Davidson-Randall	

CHIEF MAN BOY

WEDNESDAY COLLEGE

130028

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Harvey A. Jones, Sr.		2a. DATE OF DEATH MONTH DAY YEAR 4 23 85		2b. HOUR 6:45 a.m.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR January 27, 1908		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges County MD.	
10. CITY OR TOWN OF DEATH Clinton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Maryland Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Printer		12b. KIND OF BUSINESS OR INDUSTRY Gov't. Printing Office	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
13a. STATE Maryland		13b. COUNTY P.G.		13c. CITY OR TOWN Lanham		13e. STREET ADDRESS / ZIP CODE 7907 Dawnwood Court 20706	
14. FATHER'S NAME FIRST MIDDLE LAST Alexander Hamilton Jones				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Alice Williams			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 577-40-9853		17. INFORMANT Address Address Same as No# 13e.			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST.</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CITRONIC REPARATORY FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>CITRONIC PNEUMONIA</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7.5 W/C.S.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>STROKE</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>3/6</u> , 19 <u>85</u> , to <u>4/23</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>4/23</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Michael J. Ferrie</u>				DEGREE <u>MD</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>MARCH 23, 1985</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Dr. M. Levine M.D.</u>				22e. ADDRESS <u>7801 Old Branch Ave., Clinton, MD.</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4-26-85		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood P.G. Maryland	
24. FUNERAL DIRECTOR NAME ADDRESS F. Gasch's Sons F.H. P.A. Hyattsville, Maryland				25a. DATE REC'D. BY REGISTRAR MAY 8 1985			
				25b. REGISTRAR'S SIGNATURE <u>James A. ...</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M
 BP _____
 DHMH - 17
 (VR A15 ME (5))

 STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

 1- FOR
 STATE
 REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Elise A. Jorgensen - (Middle Initial - A.K.A. - B)		2a. DATE KNOWN OF DEATH MONTH DAY YEAR 4/10 19 85		2b. DATE OF ESTI- MATED DEATH MONTH DAY YEAR 4/10 19 85	
3 SEX Female	4 RACE White	5. DATE OF BIRTH MONTH DAY YEAR Feb. 27, 1908	6 AGE (IN YEARS) LAST BIRTHDAY 77 YRS.	IF UNDER 1 YR. MONTHS DAYS 77	IF UNDER 24 HRS. HOURS MIN. 77
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Norway		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH Seabrook		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Seabrook Railroad Crossing		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk	
13a. STATE Maryland		13b. CITY OR TOWN Prince George's		13c. STREET ADDRESS 9807 Locust Avenue 20706	
14. FATHER'S NAME FIRST MIDDLE LAST Andras Naro		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Karen Elise Neilsen		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No	
16b. SOCIAL SECURITY NO. 103-30-9275		17. INFORMANT ADDRESS Address Same as Mr. Ernest B. Jorgensen, Jr. No# 13e.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple injuries. 8052 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) None					
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 11:55 P.M. 4/10 19 85		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART I OR PART 2) Hit by train	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Railroad Crossing		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Seabrook Crossing, Seabrook, Prince George's, Md.	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>[Signature]</i>		TITLE (SPECIFY) Deputy		DATE SIGNED 4/10/85	
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, M.D.		ADDRESS 1919 Seminary Road Silver Spring, Montgomery, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 4-13-85		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Crematory	
24. FUNERAL DIRECTOR NAME F. Gasch's Sons F.H. P.A.		ADDRESS Hyattsville, Maryland		25a. DATE REC'D BY REGISTRAR APR 18 1985	
25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		25c. REGISTRAR'S NAME P.G. Maryland			

Office - (Address listed) - (Personnel)
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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HELENA LOUISE JULY			2a. DATE OF DEATH MONTH DAY YEAR 4 20 85			2b. HOUR 10-5A.M.	
3. SEX F		4. RACE B		5. DATE OF BIRTH MONTH DAY YEAR Mar. 19, 1932		6. AGE (IN YEARS LAST BIRTHDAY) 53 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges County MD.	
10. CITY OR TOWN OF DEATH Lanham		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Doctors' Hosp. of Prince George's				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cty Nursing Assistance	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Maryland				13c. CITY OR TOWN Prince Georges Forestville		13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO	
14. FATHER'S NAME FIRST MIDDLE LAST Oscar Boyd				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ruth Jones			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 242 42 2625		17. INFORMANT ADDRESS Patricia Wilhite-daughter-7806 Berry Place, Forestville, Maryland			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cardiopulmonary Arrest

DUE TO, OR AS A CONSEQUENCE OF

(b)

Hypovolemic Shock; Gastrointestinal Bleeding

DUE TO, OR AS A CONSEQUENCE OF

(c)

Plasma Cell LeukemiaAPPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 11c

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 4-17-85 to 4-20-85 , that (I) (we) lost saw the deceased alive on 4-20-85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							

22b. SIGNATURE G. M. DIN, M.D.		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4-20-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) G. M. DIN, M.D.		22e. ADDRESS 6510 Kenilworth Ave, Riverdale M.D. 20737					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE April 25, 1985		23c. NAME OF CEMETERY OR CREMATORY Harmony Memorial		23d. LOCATION CITY OR TOWN COUNTY STATE Park Landover, Maryland	
24. FUNERAL DIRECTOR NAME Stewart				25a. DATE REC'D. BY REGISTRAR APR 23 1985		25b. REGISTRAR'S SIGNATURE William Hamlett	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) JOSEPH JUNG			2a. DATE OF DEATH MONTH DAY YEAR APRIL 19, 1985		2b. HOUR 3:00P_M				
3. SEX Male		4. RACE Cauc.		5. DATE OF BIRTH MONTH DAY YEAR April 3, 1917		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Hawaii		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD			
10. CITY OR TOWN OF DEATH Lanham		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Doctors' Hospital of Prince Geo Co			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Engineer		12b. KIND OF BUSINESS OR INDUSTRY Electrical		
13a. STATE Md.			13b. COUNTY Pr. Geo's		13c. CITY OR TOWN Seabrook		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET ADDRESS / ZIP CODE 9789 Goodluck Rd. 20706			14. FATHER'S NAME FIRST MIDDLE LAST Do Chung		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lee Bong AI			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes WWII	
16b. SOCIAL SECURITY NO. 576-01-3475			17. INFORMANT Alma G. Jung			ADDRESS 9789 Goodluck Rd. - Seabrook, Md. 20706			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis DUE TO, OR AS A CONSEQUENCE OF (b) Colon Carcinoma - widespread DUE TO, OR AS A CONSEQUENCE OF (c) metastases Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH one 1/2 hr		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)									
19a. DATE OF OPERATION 4/15/85			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 2 P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 4/15/85 19 85 to 4/19/85 19 85 , that (I) (we) last saw the deceased alive on 4/15/85 19 85 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Harold L. Sandler			DEGREE MD			22c. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Harold L. Sandler			22e. ADDRESS 7500 Hanover Parkway, Suite 205 Greenbelt, Md. 20770						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 26 Apr. 1985		23c. NAME OF CEMETERY OR CREMATORY Forest Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Birmingham Wisconsin		
24. FUNERAL DIRECTOR NAME Howard Hales Lanham Funeral			25. DATE REC'D. BY REGISTRAR APR 25 1985			26. REGISTRAR'S SIGNATURE John Truitt			

MEDICAL CERTIFICATION

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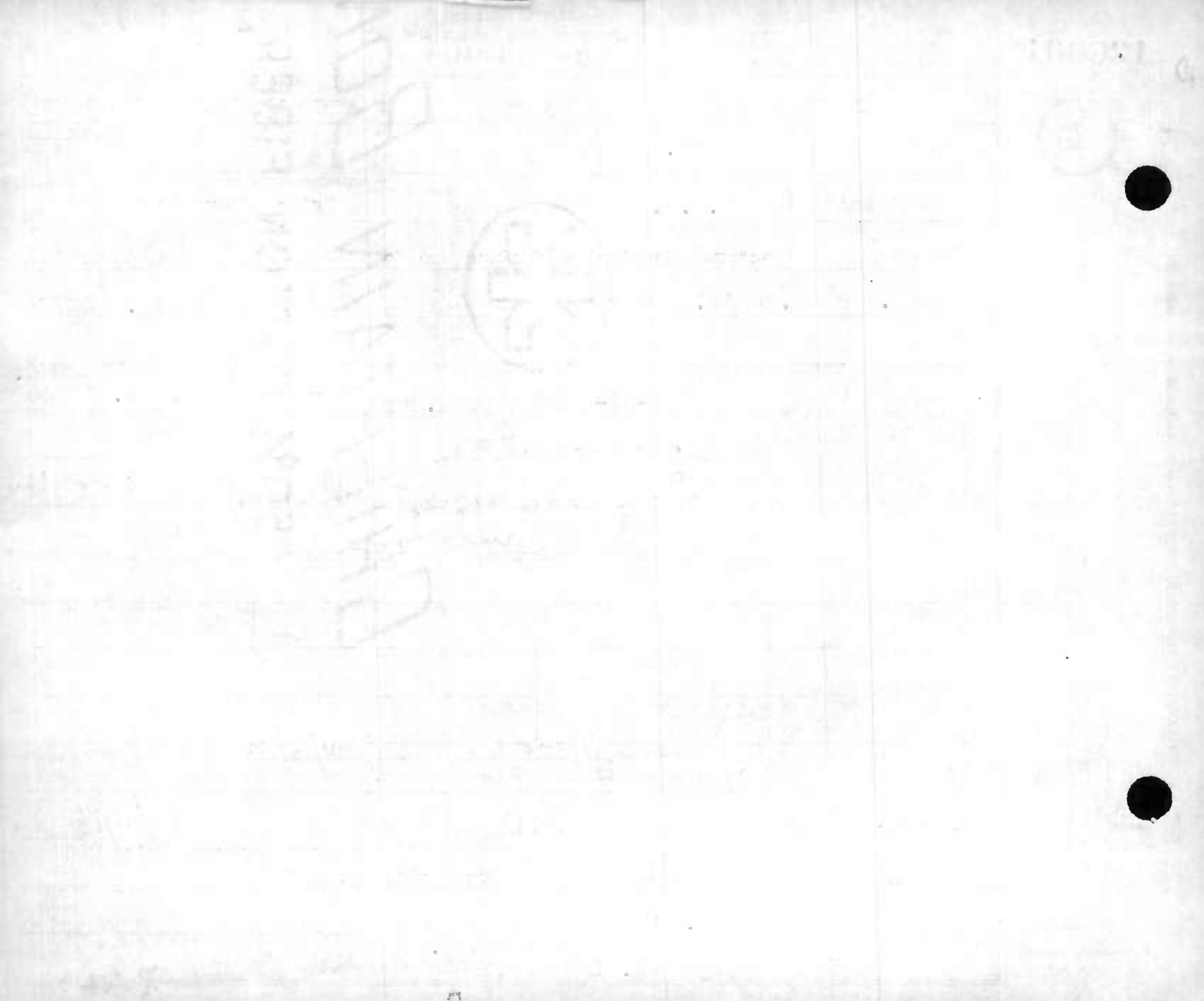
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED. WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 1 2 3 2 0	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Timothy L. Kemp										2a. DATE KNOWN OF DEATH ESTI. MATED <input checked="" type="checkbox"/> MONTH DAY YEAR 4 6 19 85	
3. SEX Male		4. RACE Negro		5. DATE OF BIRTH MONTH DAY YEAR 1 24 53		6. AGE (IN YEARS LAST BIRTHDAY) 32 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 4 6 19 85	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Alabama		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George County MD					
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince George General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Manager		12b. KIND OF BUSINESS OR INDUSTRY Restaurant			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN Wash. D.C.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 109 Elmira St. S.W. 99999			
14. FATHER'S NAME FIRST MIDDLE LAST William L. Kemp, Sr.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eloise E. Jackson							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) yes		(IF YES, GIVE WAR OR DATES) 1977- 1981		16b. SOCIAL SECURITY NO. 417-74-1265		17. INFORMANT ADDRESS William L. Kemp, Sr. same as item 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gun shot wound of chest Weapon: Unspecified DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 3:20P. 4/6 19 85		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject shot while at work					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Restaurant		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Holly Farms Rest, 5120 Burrough Ave NE, Washington, DC					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Margarita A. Korell				TITLE (SPECIFY) M.D. Assistant				DATE SIGNED 4/7/85			
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.				ADDRESS 111 Penn Street, Balto., MD 21201							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/12/85		23c. NAME OF CEMETERY OR CREMATORY Quantico Nat. Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Quantico Va.			
24. FUNERAL DIRECTOR NAME G.P. Kalas 6160 Oxon Hill Rd. Oxon Hill, Md.						25a. DATE REC'D. BY REGISTRAR APR 11 1985		25b. REGISTRAR'S SIGNATURE			

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) DOROTHY LUCILLE KENT KENT			2a. DATE OF DEATH MONTH 04 DAY 29 YEAR 85			2b. HOUR 8:02 AM			
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH Feb. DAY 1 YEAR 1930		6. AGE (IN YEARS (LAST BIRTHDAY)) 55		7. IF UNDER 1 YEAR MONTHS YRS. DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Hopewell, VA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD.			
10. CITY OR TOWN OF DEATH Clinton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Md Hospital				12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE MD		13b. COUNTY Pr. Geo.		13c. CITY OR TOWN Clinton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 6700 Simmons Lane 20735	
14. FATHER'S NAME FIRST Henry MIDDLE Milton LAST Waller					15. MOTHER'S MAIDEN NAME FIRST Grace MIDDLE Marrler LAST Marrler				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 230-30-9729		17. INFORMANT husband ADDRESS 6700 Simmons La. Kenneth H. Kent Clinton, MD 20735				

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Lymphocyte Lymphoma		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 months
DUE TO, OR AS A CONSEQUENCE OF (b) _____		
DUE TO, OR AS A CONSEQUENCE OF (c) _____		

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

Hypercalcemia, Dysautonomia, or tetraparesis

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from May 18 , 19 80 , to April 29 , 19 85 , that <input type="checkbox"/> (we) lost saw the deceased alive on April 28 , 19 85 , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input type="checkbox"/> (we) (did) (did not) view the body after death.							
22b. SIGNATURE Ronald L. Landman MD				DEGREE M.D.		22c. DATE SIGNED 4/29/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Ronald Landman MD				22e. ADDRESS 9440 Pennsylvania Ave Upper Marlboro MD			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/2/85		23c. NAME OF CEMETERY OR CREMATORY Trinity Mem. Gardens		23d. LOCATION CITY OR TOWN Waldorf COUNTY Charles STATE MD	
24. FUNERAL DIRECTOR NAME Hunt Funeral Home, Waldorf, MD 20601				25a. DATE REC'D. BY REGISTRAR MAY 02 1985			
				25b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and it may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) LILLIAN MAE KIESSLING		2a DATE OF DEATH MONTH DAY YEAR 04 14 85		2b HOUR 7:15 PM	
3 SEX Female		4 RACE Caucasian		5 DATE OF BIRTH MONTH DAY YEAR Sept. 23, 1894	
6a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kansas		6b CITIZEN OF WHAT COUNTRY? USA		6 AGE (IN YEARS LAST BIRTHDAY) 90 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
10 CITY OR TOWN OF DEATH CLINTON		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Md Hospital		9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S MD	
12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b KIND OF BUSINESS OR INDUSTRY Own home			
13a STATE MD		13b COUNTY Charles		13c CITY OR TOWN Waldorf	
14 FATHER'S NAME FIRST MIDDLE LAST William F. Caslow		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Cinderella Bateman		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. 577-30-3658		17 INFORMANT daughter ADDRESS Box 147	
				Edna E. Hershey Nanjemoy, MD 20662	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD AND CONGESTIVE HEART FAILURE					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) Uncontrolled Diabetes Mellitus					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Renal failure					
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 4/14/85 19 85 to 4/14/85 19 85 , that (I) (we) lost saw the deceased alive on 4/14/85 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death					
22b SIGNATURE OF PHYSICIAN A. G. GONSA LVES				22c DATE SIGNED 4/15/85	
22d PHYSICIAN'S NAME (TYPE OR PRINT) A. G. GONSA LVES				22e ADDRESS Waldorf, MD 20601	
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 4/17/85		23c NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	
24 FUNERAL DIRECTOR NAME Hunt Funeral Home, Waldorf, MD 20601		25a DATE REC'D. BY REGISTRAR APR 17 1985		25b REGISTRAR'S SIGNATURE Waldorf-Randall	

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

101106

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Joung Young		2a. DATE OF DEATH MARCH 28 1985		2b. HOUR 1:30p	
3. SEX Male		4. RACE Oriental		5. DATE OF BIRTH Oct. 3, 1932	
6. AGE (IN YEARS LAST BIRTHDAY) 52		7. IF UNDER 1 YEAR MONTHS DAYS		7b. IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Korea		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH Lanham		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Doctors' Hospital of Pr. Geo. Co		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Technician		12b. KIND OF BUSINESS OR INDUSTRY Retail		13. STREET ADDRESS / ZIP CODE 5307 85th Ave. 20787	
14. FATHER'S NAME Heung Suk		15. MOTHER'S MAIDEN NAME Jung		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no	
17. SOCIAL SECURITY NO. 231/06/4190		18. INFORMANT Won Sik Kim (same as # 13)		19. ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Portosystemic encephalopathy</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Liver cirrhosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>active progressive hepatitis-B</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>March 28</u> , 19 <u>85</u> , to <u>March 28</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>March 28</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Jae Sung Chung, MD</u>		DEGREE MD		22c. DATE SIGNED 3/28/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JAE S. CHUNG		22e. ADDRESS 9470 Annapolis Rd. Lanham, MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 30 March 85		23c. NAME OF CEMETERY OR CREMATORY Norbeck Mem. Pk.	
23d. LOCATION CITY OR TOWN COUNTY STATE Olney Mont. Md.					
24. FUNERAL DIRECTOR NAME Hales Lanham FH 905 Annapolis Rd Lanham MD 20786		ADDRESS		25a. DATE REC'D. BY REGISTRAR APR 04 1985	
25b. REGISTRAR'S SIGNATURE Julia Davidson-Rendell					

101102

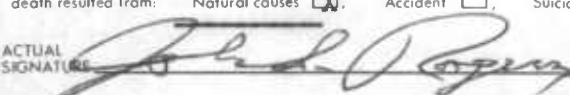
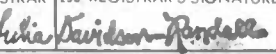


APR 04 1968

105042

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										1 2 3 2 4 REG. NO.	
1- FOR STATE REGISTRAR											
1 DECEASED NAME (TYPE OR PRINT) Louis Cecil Kiser										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> MONTH DAY YEAR 3/29 19 85 P. A.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb. 20, 1916		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.		IF UNDER 1 YR. MONTHS DAYS		2c. DATE PRONOUNCED DEAD 3/31 19 85 HOURS MIN. 11:24 A.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Va.				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD	
10. CITY OR TOWN OF DEATH Mitchellville				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3704 Lottsford Vista Road				12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) Dept. of Agriculture		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland				13b. COUNTY Prince George's				13c. CITY OR TOWN Mitchellville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> 3704 Lottsford Vista Road	
14. FATHER'S NAME FIRST MIDDLE LAST Andrew Jackson Kiser				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Victoria (na) Ayers							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. 216/12/4490		17. INFORMANT Jack Kiser				ADDRESS Seabrook Md. 9823 Goodluck Rd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial disease. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I id None											
19a. DATE OF OPERATION None				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) None					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE 				TITLE (SPECIFY) Deputy M.D. 1919 Seminary Road				DATE SIGNED 4/1/85			
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, M.D.				ADDRESS Silver Spring, Montgomery, Md.							
23a. BURIAL, CREMATION, REMOVAL Burial				23b. DATE 3 April 85		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln				23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood P.G. Md.	
24. FUNERAL DIRECTOR NAME Hales Latham				ADDRESS Ft. 9013 Annapolis Rd Latham Md				25a. DATE REC'D. BY REGISTRAR APR 08 1985		25b. REGISTRAR'S SIGNATURE 	

07/84
25M

BP

DHMH - 17
(VR A15 ME (5))

DATE: 10/10/60
TIME: 11:00 AM
PLACE: Prince George's County
SUBJECT: Prince George's County
REMARKS: Prince George's County
105043

Prince George's County
105043
Prince George's County
105043

Acute myocardial infarction



None

None

None

X

X

John A. Hovatta, M.D.
Silver Spring, Montgomery, Md.
105043

113019

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Henry William Kneipp		2a. DATE KNOWN OF DEATH ESTI MATED April 14, 1980		2b. DATE PRONOUNCED DEAD April 14, 1980	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 03 09 1893	6. AGE (IN YEARS) LAST MONTH DAY 92	7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN	8. IF UNDER 24 HRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County		10. CITY OR TOWN OF DEATH Hyattsville		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6000 42nd Avenue Apt. 309	
12a. USUAL OCCUPATION (TYPE OF WORK) Bookbinder		12b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.		13. STREET ADDRESS 6000 42nd Avenue Apt. 309	
13a. STATE Maryland		13b. COUNTY P.G.		13c. CITY OR TOWN Hyattsville	
14. FATHER'S NAME FIRST MIDDLE LAST Frederick Kneipp		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Kate Unknown		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No	
16b. SOCIAL SECURITY NO. 579-58-2344		17. INFORMANT William H. Kneipp (Son)		ADDRESS 5908 Bryn Mawr Rd College Park, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Dist.</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) <u>Chronic Myocardial Dist.</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Yrs					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>None</u>					
19a. DATE OF OPERATION <u>None</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE <u>John S. Rogers</u>		TITLE (SPECIFY) M.D. <u>Dep</u>		MEDICAL EXAMINER DATE SIGNED <u>April 14, 1980</u>	
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, M.D.		ADDRESS 1919 Seminary Rd. Silver Spring, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/17/85		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery	
23d. LOCATION CITY OR TOWN Brentwood		COUNTY P.G.		STATE Maryland	
24. FUNERAL DIRECTOR Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue Hyattsville, Md. 20781				25. DATE REC'D BY REGISTRAR APR 18 1985	
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>					

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(VR A15 ME (5))

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IN 24 HOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL- TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 2 3 2 6

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) WITHROW V. KNODE			2a. DATE KNOWN OF DEATH MONTH DAY YEAR 4/5 1985		2b. HOUR M 11:55
3. SEX MALE	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR 10 19 24	6. AGE (IN YEARS) (LAST BIRTHDAY) 60 YRS.	IF UNDER 1 YR. MONTHS DAYS 0 0	IF UNDER 24 HRS. HOURS MIN. 0 0
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. CITY OR TOWN OF DEATH BOWIE		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BOWIE HEALTH CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Electronic Technician/Metro	
13a. STATE MARYLAND		13b. CITY OR TOWN PRINCE GEORGE'S BOWIE		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Daniel Preston Knode			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Vista Kretzer		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. WW II 219-14-8340		17. INFORMANT ADDRESS 4009 Woodhaven Lane Frances C. Knode Bowie, Maryland 20715	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Isolated arteriosclerotic cerebrovascular disease DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE <i>Augusto P. Rodriguez</i>		TITLE (SPECIFY) M.D. Deputy		DATE SIGNED 4-5-85	
EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez, M.D.		ADDRESS 5009 Rayburn Ct., Temple Hills, Md			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE April 11, 1985		23c. NAME OF CEMETERY OR CREMATORY Maryland Veterans Cem.	
24. FUNERAL DIRECTOR NAME Beall Funeral Home		ADDRESS 16000 Annapolis Road Bowie, MD 20715-3043		25a. DATE REC'D. BY REGISTRAR APR 9 1985	
				25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

07/84
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DHMH - 17
(VR A15 ME (5))

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1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1 2 3 2 7

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR					
Mary Grace Lambert								4-4		19		85				M					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR		2d. HOUR	
Female		White		1-21-93		92 YRS.						4-4		19		85		6:30		M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH													
Maryland		USA						Prince George's County, MD													
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY															
Clinton		5601 Kirby Road		Homemaker		Home															
13a. STATE		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13d. STREET ADDRESS															
Maryland		Prince George's		Clinton		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		5601 Kirby Road (20735)													
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME																			
Washington Hardesty		Emma Williams																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS															
No		N/A		577-84-2153		Ralph E. Lambert - Same As #13 A-E															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Anteroplusfic cardiac/muscular disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a.																					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?																	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE																	
22a. I certify that I took charge of the remains described above, held on		Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion		death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE <u>Augusto P. Rodriguez</u>		TITLE (SPECIFY) M.D. Deputy		DATE SIGNED <u>4-4-85</u>																	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS		5009 Rayburn Ct., Temple Hills, Md																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE															
Burial		April 8, 1985		Fort Lincoln Cemetery		Brentwood, Maryland															
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE																	
Lee Funeral Home, Inc.		APR 9 1985		Davidson-Randall																	
6633 Old Alexander Ferry Road, Clinton, Maryland																					

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE
EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR.
PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS
AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET,
BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.07/84
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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) SHEROSH (NMI) LAPUTZ			2a. DATE OF DEATH MONTH DAY YEAR 04 11 85			2b. HOUR 7.40PM _M			
3 SEX Male		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR 01 21 1923		6 AGE (IN YEARS LAST BIRTHDAY) 62		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
8 BIRTHPLACE (STATE OR FOREIGN COUNTRY) Connecticut		9b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S MD.			
10 CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION PRINCE GEORGE'S GENERAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY Navy	
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Maryland		13b. COUNTY P.G.		13c. CITY OR TOWN Hyattsville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST Jerry Laputz				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Fedora Shemit					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF KNOWN, GIVE LAST FOUR DIGITS) Navy		17. INFORMANT ADDRESS Alice D. Laputz (Wife) Same as 13c					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cardiac arrest on admission</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>4/7/85</u> , 19 <u>85</u> to <u>4/11/85</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>4/11</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>[Signature]</u>						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>4/11/85</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>M. G. HASH M.D.</u>						22e. ADDRESS <u>PGCH</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 4/15/85		23c. NAME OF CEMETERY OR CREMATORY Arlington National Cem. Ft. Myer			23d. LOCATION COUNTY STATE Arlington Virginia	
24. FUNERAL DIRECTOR Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Ave. Hyattsville, Md. 20781						25a. DATE REC'D. BY REGISTRAR APR 18 1985			
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>									

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR				20. DATE OF DEATH MONTH DAY YEAR				20. HOUR	
1. DECEASED NAME FIRST MIDDLE LAST PAUL LaVORGNA				20. APRIL 13, 1985				7:22PM	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Jan. 24 1914		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES COUNTY MD.			
10. CITY OR TOWN OF DEATH CLINTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTHERN MARYLAND HOSPITAL CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Butcher		12b. KIND OF BUSINESS OR INDUSTRY Sunshine Market	
13a. STATE Maryland				13b. COUNTY Charles		13c. CITY OR TOWN Waldorf		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST B'Agio LaVorgna				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Munzia Cofrancesco					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (# YES, GIVE WAR OR DATES) 143-07-4644		17. INFORMANT ADDRESS Josephine H. LaVorgna Waldorf, Md. 206 Bell Tree Lane					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>coronary artery disease</u> DUE TO, OR AS A CONSEQUENCE (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) the hospital attended the deceased from 4/13 1985 to 4/13 1985, that (1) <u>lost</u> saw the deceased alive <u>DOA</u> 19, and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (1) <u>was not</u> seen the body after death.									
22b. SIGNATURE <u>[Signature]</u>				DEGREE				22c. DATE SIGNED 4/13/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Frank N. Ryan M.D.				22e. ADDRESS 9401 Tussock Hill, Ft. Wash Md 20744					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/17/85		23c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Clinton P.G. Maryland			
24. FUNERAL DIRECTOR NAME George P. Kalas Funeral Home				6160 Oxon Hill Rd. ADDRESS		25a. DATE REC'D. BY REGISTRAR APR 17 1985		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1 - STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Francis Douglas League, Sr.			2a. DATE OF DEATH MONTH DAY YEAR 04-06-85		2b. HOUR 8 15AM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 01 22 1912		
6. AGE (IN YEARS LAST BIRTHDAY) 73		7. IF UNDER 1 YEAR MONTHS DAYS YRS		8. IF UNDER 24 HRS. HOURS MIN. MD.		
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		9b. CITIZEN OF WHAT COUNTRY? U.S.A.		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S		
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S GENERAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Satelite Design		
12b. KIND OF BUSINESS OR INDUSTRY NASA		13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY P.G.		
13c. CITY OR TOWN Hyattsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 6813 Decatur Street 20784		
14. FATHER'S NAME FIRST MIDDLE LAST William Frank League		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maud Lillian Hilds		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		
16b. SOCIAL SECURITY NO. 212-07-6065		17. INFORMANT ADDRESS Dorothy M. League 6813 Decatur St. 20784		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Motor Vehicle Accident</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (this hospital) attended the deceased from <u>4/5</u> , 19 <u>85</u> , to <u>4/6/85</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>4/5</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE <u>Barry Rosenberg</u>		DEGREE <u>MD</u>		22c. DATE SIGNED <u>4/6/85</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Barry Rosenberg, MD.		22e. ADDRESS Prince Georges General Hospital				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/9/85		23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery		
23d. LOCATION CITY OR TOWN COUNTY Pikesville Baltimore MD.		24. FUNERAL DIRECTOR NAME ADDRESS Hubbard Funeral Home, Inc. 4107 Wilkens Avenue 21229				
25a. DATE REC'D. BY REGISTRAR APR 8 1985		25b. REGISTRAR'S SIGNATURE <u>John Davidson-Pond</u>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 4 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

101005



PRINCE OF WALES GENERAL HOSPITAL

PRINCE OF WALES

101104

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF DEATH			MONTH DAY YEAR			2b. HOUR			
Naomi Margaret Lenhardt						3/25 19 85			A. M.			3:35			
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD			MONTH DAY YEAR			2d. HOUR			
Female	Black	Oct 25, 1905	79 YRS.			3/25 19 85			A. M.			3:35			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH						
South Carolina			U. S. A.						Prince George's County MD						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
Hyattsville			2205 Rittenhouse Street			Beautician			Private						
13a. STATE			13b. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS						
Maryland			Prince George's Hyattsville			YES <input type="checkbox"/> NO <input type="checkbox"/>			2205 Rittenhouse Street						
14. FATHER'S NAME						15. MOTHER'S MAIDEN NAME									
Benjamin F. Cox						Dicey McKinsey									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS						
NO			251-56-9873			Ruby T. McMullen, Daughter, Hyattsville, Md.			2305 Rittenhouse St.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I DEATH WAS CAUSED BY:															
IMMEDIATE CAUSE (a) <u>Acute myocardial disease</u>															
DUE TO, OR AS A CONSEQUENCE OF															
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.															
(b) <u>chronic myocardial disease.</u>															
DUE TO, OR AS A CONSEQUENCE OF															
(c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1															
None															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?					
None										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
				P.M. 19				None							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION							
								CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE				TITLE (SPECIFY)						DATE SIGNED					
<i>John S. Rogers</i>				Deputy MEDICAL EXAMINER						3/25/85					
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS											
John S. Rogers, M.D.				1919 Seminary Road Silver Spring, Montgomery, Md.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION					
BURIAL				1 Apr 85		Harmony Memorial Park				Landover, P. G. Co., Maryland					
24. FUNERAL DIRECTOR				NAME				25a. DATE OF DAY REGISTRATION				25b. REGISTRAR'S SIGNATURE			
W. ERNEST JARVIS CO., INC.				1432 You St., NW, Washington, D. C.				APR 03 1985				<i>John S. Rogers</i>			

07/84
25MBP
DHMH - 17
(VR A15 ME (5))

chronic myocardial disease.



APR 3 1962

John E. ...

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None

None

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Myocardium ...

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MEDICAL EXAMINER NOTIFIED AND RELEASED PER POLICE ORDER # 85-997-412

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 is marked, injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST MILDRED LEVITON		2a. DATE OF DEATH MONTH DAY YEAR APRIL 7, 1985	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR JUNE 20, 1909	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) RUSSIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		6. AGE (IN YEARS LAST BIRTHDAY) 75 IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
10. CITY OR TOWN OF DEATH COLLEGE PARK		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6200 WESTCHESTER PARK DRIVE		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SALESPERSON		12b. KIND OF BUSINESS OR INDUSTRY SAKS 5TH AVE. 20740		13a. STREET ADDRESS 6200 WESTCHESTER PARK DR.	
13a. STATE MARYLAND		13b. COUNTY PR. GEORGES		13c. CITY OR TOWN COLLEGE PARK	
14. FATHER'S NAME FIRST MIDDLE LAST DANIEL LEVITOFF		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST VERA BERMAN		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	
16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 577-16-2413		17. INFORMANT (SON) DANIEL LEVITON, 2007 PELDEN RD., ADELPHI, MD.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrhythmia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic and hypertensive cardio</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>vascular disease</u> Approximate interval between onset and death: <u>5 minutes</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a <u>metastatic adenocarcinoma of the lung.</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from <u>3.26</u> , 19 <u>75</u> , to <u>4.7</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>3.28</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE Oriel C. Morris MD		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/7/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ORIEL C. MORRIS, M.D.		22e. ADDRESS 2121 PENNSYLVANIA AVE., N.W., WASHINGTON, D.C.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 4/9/85		23c. NAME OF CEMETERY OR CREMATORY MT. LEBANON CEMETERY	
23d. LOCATION CITY OR TOWN COUNTY STATE ADELPHI PG MD.		24. FUNERAL DIRECTOR NAME ADDRESS RICHARD RAPP, INC. 1804 T ST., N.W., WASHINGTON, D.C. 20009			
25a. DATE REC'D. BY REGISTRAR APR 9 1985		25b. REGISTRAR'S SIGNATURE Rendell			

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UNITED STATES DEPARTMENT OF AGRICULTURE

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE MEDICAL EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE FUNERAL DIRECTOR. GIVE PAGE 5 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR OFFICE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED. WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) LAWRENCE DANIEL LEYH, SR.						2a. DATE KNOWN OF DEATH MONTH DAY YEAR 4-5-1985		2b. HOUR 3:14a	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 30, 1905 79		6. AGE (IN YEARS) LAST BIRTHDAY MONTHS DAYS HOURS MIN 79 YRS.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 4-5-1985	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD	
10. CITY OR TOWN OF DEATH LANHAM				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DOCTORS' HOSPITAL of P.G. Co.				12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) Auto Mechanic	
13a. STATE Maryland				13b. COUNTY P.G.		13c. CITY OR TOWN Berwyn Heights		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Frederick Casper Leyh				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Teresa Bothe					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 145 03 0783		17. INFORMANT ADDRESS 6305 Amherst Avenue Laurence D. Leyh, Jr. Columbia, Md. 21046			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intense pulmonary cardiac prostatic disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .									
ACTUAL SIGNATURE Augusto P. Rodriguez				TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER				DATE SIGNED 4-5-85	
EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez, M.D.				ADDRESS 5009 Rayburn Ct., Temple Hills, Md					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/8/85		23c. NAME OF CEMETERY OR CREMATORY George Washington Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Adelphi P.G. Maryland			
24. FUNERAL HOME OR ADDRESS Francis Casch's Sons Funeral Home, P.A. 4739 Baltimore Avenue Hyattsville, Md. 20781						25a. DATE REC'D. BY REGISTRAR APR 11 1985		25b. REGISTRAR'S SIGNATURE [Signature]	

07/84
25M

BP _____
DHMH - 17
(VR A15 ME (5))

100002

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Clinton G. Light			2a. DATE OF DEATH MONTH DAY YEAR April 15, 1985			2b. HOUR 2:19P M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 03 23 1913		6. AGE (IN YEARS LAST BIRTHDAY) 72		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD.			
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Pr. Geo. Gen. Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Professional Engineer		12b. KIND OF BUSINESS OR INDUSTRY PEPCO	
13a. STATE Maryland			13b. COUNTY P.G.		13c. CITY OR TOWN Cheverly		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Clinton G. Light			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna J. Morrison			16. STREET ADDRESS / ZIP CODE 3007 Crest Avenue 20785			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes-Navy			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W.W.II		17. INFORMANT Paul D. Light (Son)		ADDRESS 216 Harbor Drive Severna Park, Md. 21146		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure EOPD DUE TO, OR AS A CONSEQUENCE OF (b) pulmonary infiltrate DUE TO, OR AS A CONSEQUENCE OF (c) Septic Shock CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last. one month 3 days									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 3-11 , 19 85 to 4-15 , 19 85 , that (I) (we) last saw the deceased alive on 4-15 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Obannes Sahakian, M.D.						22c. DATE SIGNED 4-16-85		22d. PHYSICIAN'S NAME (TYPE OR PRINT) Obannes Sahakian, M.D.	
22e. ADDRESS 5632 Annapolis Road - Bladensburg, Maryland						22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 4/18/85		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland P.G. Maryland		
24. FUNERAL DIRECTOR NAME F. Gasch's Sons F.H. P.A. Hyattsville, Maryland						25. REC'D. BY REGISTRAR APR 18 1985		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, please enter any injury or other traumatic event, the medical examiner must be contacted immediately.



Info

White

Clinton

Light

April 15, 1967

2-137

Spring Grove's County

Dr. Geo. Geo. Hospital

Chemistry

For-View

2-11

[Faint, illegible handwritten notes]

4-15-67

x

1022 Memphis Road - Washington, Maryland

Thomas Jackson, Jr.

F. M. Jones, Jr., H. A. Boyceville, Maryland

105145

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) JEANETTE P. List			2a. DATE OF DEATH MONTH 04 DAY 04 YEAR 85 2b. HOUR 8:00AM		
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH October DAY 25 YEAR 1929	6. AGE (IN YEARS (LAST BIRTHDAY)) 55 YRS.	7. IF UNDER 1 YEAR MONTHS 04 DAYS 04 HOURS 08 MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Iowa	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD.		
10. CITY OR TOWN OF DEATH CLINTON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Md Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Real Estate Agent	12b. KIND OF BUSINESS OR INDUSTRY Real Estate	
13a. STATE Maryland			13b. CITY OR TOWN Prince George's Silver Hill		
14. FATHER'S NAME FIRST George F. MIDDLE Powers LAST 			15. MOTHER'S MAIDEN NAME FIRST Grace M. MIDDLE Pierce LAST 		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT 814 Bellwood Lane Walter V. Gray California, Maryland 20619	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular accident DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (c) 					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Myocardial infarction					
19a. DATE OF OPERATION 3/27/85		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Myocardial infarction		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 3/27/85 19 85 to 4/3/85 19 85 , that (I) (we) last saw the deceased alive on 4/3/85 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Glenn R. Jancian		DEGREE MD		22c. DATE SIGNED 4/4/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Glenn R. Jancian		22e. ADDRESS 9450 Penn. Ave. Upper Marlboro			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE April 5, 1985		23c. NAME OF CEMETERY OR CREMATORY Lee's Crematory	
23d. LOCATION CITY OR TOWN Clinton, Maryland		23e. LOCATION COUNTY STATE			
24. FUNERAL DIRECTOR NAME Lee Funeral Home, Inc.		24b. ADDRESS Old Alexander Ferry Road, Clinton, Maryland		25a. DATE REC'D. BY REGISTRAR APR 9 1985	
25b. REGISTRAR'S SIGNATURE John Davidson-Randall					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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ended

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

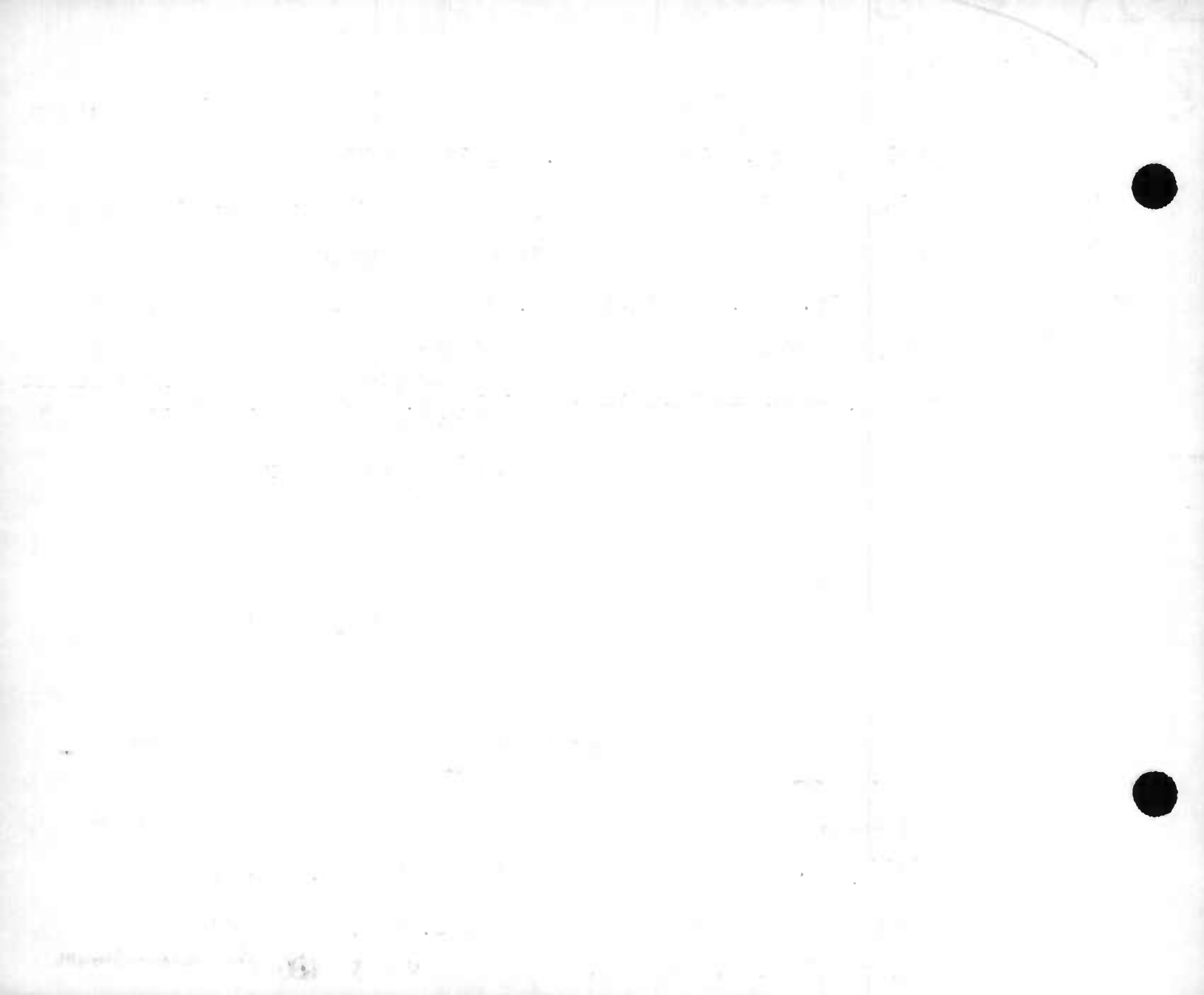
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1 - STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST TYNA VIOLA LITTLE			2a. DATE OF DEATH MONTH DAY YEAR 30 APRIL 1985		2b. HOUR 5:40pm
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR Oct. 24, 1909	6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.	7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Georgia	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD.		
10. CITY OR TOWN OF DEATH Andrews AFB	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Malcolm Grow Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	12b. KIND OF BUSINESS OR INDUSTRY Own home	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD		13b. COUNTY Pr. Geo.	13c. CITY OR TOWN Capitol Hgts.	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET ADDRESS / ZIP CODE 501 69th Street, 20743
14. FATHER'S NAME FIRST MIDDLE LAST Lerry Warren Lynch		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rosa Lee Joyce			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -----	17. INFORMANT daughter Shirley A. Doak Cap. Hgts. MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>X Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metastatic Adenocarcinoma</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>15 APRIL</u> , 19 <u>85</u> , to <u>30 APRIL</u> , 19 <u>85</u> that (I) (we) lost saw the deceased alive on <u>30 APRIL</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do) view the body after death.					
22b. SIGNATURE <u>William S. Syhrora</u>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 5/1/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) William S. Syhrora		22e. ADDRESS Andrews Air Force Base, MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 5/3/85	23c. NAME OF CEMETERY OR CREMATORY Arlington Natl. Cem.	23d. LOCATION CITY OR TOWN COUNTY STATE Arlington VA	25a. DATE REC'D. BY REGISTRAR MAY 3 1985	
24. FUNERAL DIRECTOR NAME Huntt Funeral Home, Waldorf, MD		25b. REGISTRAR'S SIGNATURE <u>Gita Davidson-Randall</u>			



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 2 3 3 7
REG. NO.

FOR
1- STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		2a. DATE KNOWN OF ESTI- DEATH MATED		2b. HOUR	
Alta Jean B. Locke		4-18 1985			
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.
Female	White	5-20-11	73		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
NORTH DAKOTA	USA		Baltimore City or County of Death		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
CHEVERLY	Prince Georges General Hospital		HOMEMAKER		N/A
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS	
Maryland	Prince Georges	Oxon Hill	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20744 1313 Southern Avenue, 407	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. SOCIAL SECURITY NO.	
ROBERT BYRNE		LUCY MAUDE RHODES		501-14-1903	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO		501-14-1903		Mr. Robert H. Byrne, St. Petersburg, Florida	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Anterograde cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to, immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		
ACTUAL SIGNATURE <u>Augusto P. Rodriguez</u> M.D. Deputy MEDICAL EXAMINER		DATE SIGNED 4-22-85
EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez, M.D. ADDRESS 5009 Rayburn Ct., Temple Hills, Md		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
CREMATION	23April85	LEE'S CREMATORY	CLINTON, P.G., MARYLAND
24. FUNERAL DIRECTOR NAME	25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE
LEE FUNERAL HOME, 6633 Old Alexander Ferry Road, Clinton, Maryland 20735	APR 25 1985		<u>Juanita W. Wadsworth</u>

DHMH - 17
(VR A15 ME (5))

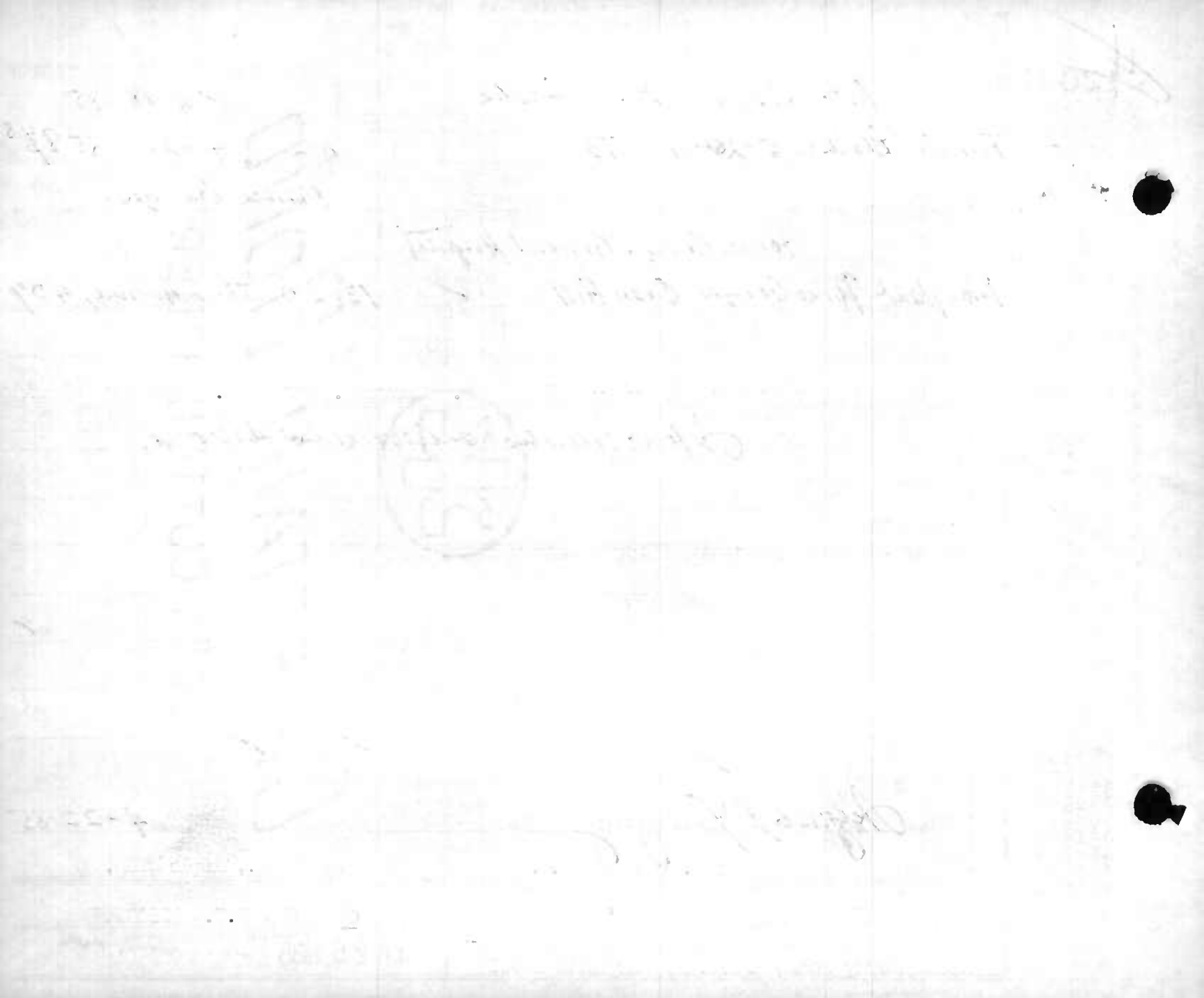
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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

BP

DHMH - 17
(VR A15 ME (5))

BP



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
Rosary Locknane				April 02, 1985		7:15P _M	
3 SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR	
FEMALE	CAUCASIAN	MONTH DAY YEAR 4 21 1923		61 YRS		IF UNDER 24 HRS	
7a. BIRTHPLACE (COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
				Prince Georges County MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
		Greater Laurel Beltsville Hospital					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13d. STREET ADDRESS / ZIP CODE	
MD.		P.G.		LAUREL		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 7678 NORTH BARRERY WAY 20707	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME					
FIRST MIDDLE LAST JAMES WILLCOX		FIRST MIDDLE LAST ROSARY TENSEN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS			
NO		394-18-1480		BUSH Wm. LOCKNANE LAUREL, MD. 20707			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOGENIC SHOCK DUE TO, OR AS A CONSEQUENCE OF (b) CARDIOMYOPATHY DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day 5 yrs							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a Ventricular Arrhythmias, Congestive Heart Failure							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE		DEGREE		22c. DATE SIGNED			
Christine		MD		4.3.85			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS					
CHRISTINE DE LIMA		14201 LANCE Pk DE LAUREL MD 20810					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
BURIAL		4-5-85		PARKLAWN Cemetery		Rockville Mont. MD.	
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
FLECK FUNERAL HOME INC.		7601 SANDYSPR. RD. LAUREL, MD. 20707		APR 8 1985		[Signature]	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1911

129017

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) CHRISTINE A. LOGAN			2a. DATE OF DEATH MONTH DAY YEAR 04-26-85		2b. HOUR 6:35AM
3. SEX Female	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 2 11 02		6. AGE (IN YEARS LAST BIRTHDAY) 83	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY	
10. CITY OR TOWN OF DEATH CHEVERLY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION PRINCE GEORGE'S GENERAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Custodial Supervisor	12b. KIND OF BUSINESS OR INDUSTRY U.S. Post Office	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD			13b. COUNTY P.G.	13c. CITY OR TOWN Cap Hts.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Wash Love			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Louise Adams		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 216-44-3236		17. INFORMANT Louise E. Logan	
			ADDRESS 408 Quarry Avenue Capitol Heights, MD 20743		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cardiac arrest

DUE TO, OR AS A CONSEQUENCE OF

(b)

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from April 20 , 19 85 , to April 25 , 19 85 , that (I) (we) last saw the deceased alive on April 25 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE P. Thomas Lyons MD		DEGREE MD	22c. DATE SIGNED 4-26-85
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PAUL THOMAS LYONS		22e. ADDRESS	

MEDICAL CERTIFICATION

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 5/1/85	23c. NAME OF CEMETERY OR CREMATORY Harmony Memorial Park	23d. LOCATION CITY OR TOWN COUNTY STATE Landover Prince George's MD
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24. FUNERAL DIRECTOR NAME ROLLINS FUNERAL HOME, INC.	25a. DATE REC'D. BY REGISTRAR MAY 06 1985	25b. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and (completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified of once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

129017

WASHINGTON, D.C. 20019
4333 HUNT PLACE, N.E.
ROLLINS FUNERAL HOME, INC.

120034

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 2 3 4 0

1. DECEASED NAME (TYPE OR PRINT) Laura H. Lord			2a. DATE OF DEATH MONTH DAY YEAR April 15, 1985		2b. HOUR 10:35PM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Oct 11 1907		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS		
10. CITY OR TOWN OF DEATH Forestville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Regency Nursing Home		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges Co. MD.		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk		12b. KIND OF BUSINESS OR INDUSTRY US Govern.				
13a. STATE Wash. DC		13b. CITY OR TOWN Washington		13c. STREET ADDRESS / ZIP CODE 2800 Eire St SE 99944		
14. FATHER'S NAME FIRST MIDDLE LAST Charles Harnsberger		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Huff				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. Unknown		17. INFORMANT Charles Lord 8226 Carrleigh Parkway Springfield, VA 22152		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))						
PART I. DEATH WAS CAUSED BY:						
IMMEDIATE CAUSE (a) <u>Pneumonia</u>						
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Organic Brain Syndrome</u>						
DUE TO, OR AS A CONSEQUENCE OF (c) _____						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>8/8/77</u> 19 <u>85</u> , to <u>4/16/85</u> 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>4/12/85</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <u>J. H. Thibadeau</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>4/16/85</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joseph H Thibadeau MD		22e. ADDRESS 3112 Alabama Ave SE Washington DC				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/18/85		23c. NAME OF CEMETERY OR CREMATORY St. Lincoln Cemetery Brentwood PG MD		
24. FUNERAL DIRECTOR NAME Robert E Wilhelm		4308 Suitland R MD		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE APR 22 1985 <u>Gail Davidson-Randall</u>		

MEDICAL CERTIFICATION

29

83

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove certain papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

110000

[Faint, illegible handwritten text and markings covering the page]

120948

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DMMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 1 2 3 4 1

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		ESTIMATED		MONTH		DAY		YEAR		2b. HOUR					
Vincent		J.		Lupo				4/21		19		85						7:38					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED		MONTH		DAY		YEAR					
Male		White		Apr. 12, 1915		70 YRS.						4/21		19		85		7:38					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		WIDOWED		DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH											
New York		US										Prince George's County MD											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY																	
Laurel		Greater Laurel-Beltsville Hospital		SHEET METAL		AS SAME																	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE		13b. CITY OR TOWN		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS													
Maryland		Prince George's		Laurel		YES		NO		15115 Laurel Ridge Drive		20707											
14. FATHER'S NAME		FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME		FIRST		MIDDLE		LAST									
GIOVANNI						LUPO		MEME				M.		GIUSEPPA									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS																	
NO		105-12-6849		NANNETTE HOWARD.		16116 LAUREL RIDGE D. LAUREL, MD. 20707																	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 1 DEATH WAS CAUSED BY:																							
IMMEDIATE CAUSE (a) Acute myocardial disease																							
DUE TO, OR AS A CONSEQUENCE OF																							
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.																							
(b) chronic myocardial disease.																							
DUE TO, OR AS A CONSEQUENCE OF																							
(c)																							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1																							
None																							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?																20. AUTOPSY?					
None																		YES		NO			
21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED																			
		HOUR A.M. MONTH DAY YEAR		P.M. 19		None																	
21d. INJURY OCCURRED WHILE AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION																			
NOT WHILE AT WORK																							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																							
ACTUAL SIGNATURE		TITLE (SPECIFY)		MEDICAL EXAMINER		DATE SIGNED																	
John S. Rogers, M.D.		Deputy		1919 Seminary Road		4/21/85																	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS		Silver Spring, Mntgomery, Md.																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION																	
CREMATION		4/23/85		BALTO. WASH. CREMATORY		LAUREL		P.G. MD.															
24. FUNERAL DIRECTOR (NAME)		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE																			
FLECK F.H. INC.		7601 SANDY SPRING RD.		23 1985																			
		LAUREL, MD. 20707																					

1209-18

Vincent

White Apr. 12, 1902

Prince George's County

Greater Laurel-Bethesda Hospital

Laurel

1915 Laurel House Drive

Prince George's Laurel

Maryland

Acute myocardial disease

chronic myocardial disease.

None

None

None

X

X

Deputy

1019 Seminary Road

Silver Spring, Maryland, No.

John S. Rogers, M.D.

107137

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

DHMH - 18 6DM 7/84
(VRA 15, 4)1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 2 3 4 2

1. DECEASED NAME (TYPE OR PRINT) James Philip MacDONALD			2a. DATE OF DEATH MONTH DAY YEAR April 11, 1985		2b. HOUR 1:45 A M						
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 23, 1900		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.	
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maine		10. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		12. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD.					
13. CITY OR TOWN OF DEATH LANHAM		14. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DOCTORS' HOSPITAL of P.G. Co.				15. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Advertising		16. KIND OF BUSINESS OR INDUSTRY Newspaper			
17. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 17a. STATE Massachusetts				17b. CITY OR TOWN Unknown		17c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		17d. STREET ADDRESS / ZIP CODE 45 21st Street / 02539		17e. CITY OR TOWN Edgartown	
18. FATHER'S NAME FIRST MIDDLE LAST Paul - MacDonald				19. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary E. O'Brien				20. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No None			
21. SOCIAL SECURITY NO. 013-10-5521A				22. INFORMANT Betty Harney 8603 Powhatan St.				23. NEW CARROLLTON Md. 20784			
24. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Arteriosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Acute Myocarditis</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>3 days</i> 9 days											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (in) <i>Severe Bronchial Asthma</i>											
25a. DATE OF OPERATION			25b. CONDITION FOR WHICH OPERATION WAS PERFORMED			26a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		26b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
27a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			27b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			27c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)			27d. LOCATION CITY OR TOWN COUNTY STATE		
27e. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>			27f. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			27g. LOCATION CITY OR TOWN COUNTY STATE			27h. DATE SIGNED 11 Apr 85		
28a. I certify that (I) (this hospital) attended the deceased from <i>10 Apr 85</i> to <i>11 Apr 85</i> , that (I) (we) saw the deceased alive on <i>10 Apr 85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
28b. SIGNATURE <i>Thomas J. Maloney MD</i>						28c. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			28d. DATE SIGNED 11 Apr 85		
28e. PHYSICIAN'S NAME (TYPE OR PRINT) THOMAS MALONEY						28f. ADDRESS 4814 71st Ave, Hyattsville MD.					
29a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			29b. DATE April/13/85			29c. NAME OF CEMETERY OR CREMATORY Colebrook Cemetery			29d. LOCATION CITY OR TOWN COUNTY STATE Whitman, Plymouth Co., Mass.		
29e. FUNERAL DIRECTOR NAME Chambers Funeral Home						29f. ADDRESS Riverdale, Maryland			29g. DATE REC'D. BY REGISTRAR APR 15 1985		
29h. REGISTRAR'S SIGNATURE <i>Carrollton</i>						29i. REGISTRAR'S SIGNATURE <i>Carrollton</i>					

DHMH - 18 6DM 7/84
(VRA 15, 4)

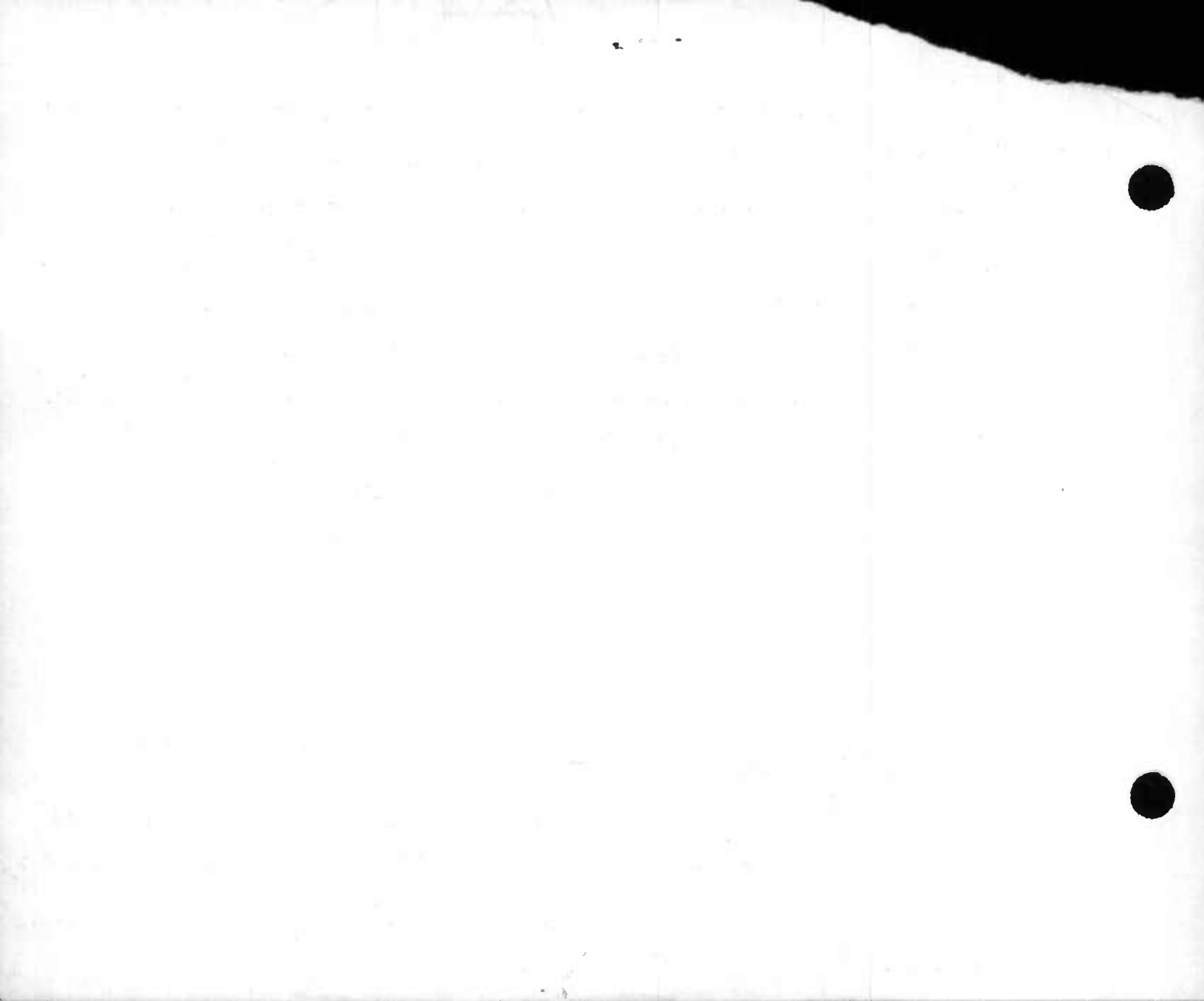


STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ETHEL MARGARET MACEIKO			2a. DATE OF DEATH MONTH DAY YEAR APRIL 8TH. 1985		2b. HOUR 4:22A
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Feb. 18, 1910	6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Vermont	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD.		
10. CITY OR TOWN OF DEATH Laurel	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GREATER LAUREL BELTSVILLE HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) (Ret.)		
13a. STATE Maryland		13b. COUNTY Howard	13c. CITY OR TOWN Jessup	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Alfred Benjamin		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret T. Kennedy			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. W.W. II 001-03-5686		17. INFORMANT (Son) ADDRESS Mr. Stephen M. Maceiko Millersville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Cardio Vascular Disease DUE TO, OR AS A CONSEQUENCE OF (c) Dehydration - Ac Gastro- enteritis PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: None					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR APR 6 1985		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from APR 6 1985 to APR 8 1985 , that (I) (we) last saw the deceased alive on APR 8 1985 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE German A. De La Torre		DEGREE MD		22c. DATE SIGNED 4-8-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GERMAN A. DE LA TORRE		22e. ADDRESS 320 Montgomery St. Laurel, Md. 20707			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE April 11, 1985		23c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Pk.	
24. FUNERAL DIRECTOR NAME R. J. Phibbs		24b. ADDRESS Singleton Funeral Home, Glen Burnie, Md.		25a. DATE RECEIVED BY REGISTRAR APR 9 1985	
25b. REGISTRAR'S SIGNATURE		25c. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) James E. MALARKEY			2a. DATE OF DEATH MONTH DAY YEAR 4 19 85		2b. HOUR 6:30 ^{AM}
3. SEX Male	4. RACE Cauc.	5. DATE OF BIRTH MONTH DAY YEAR 9 24 15	6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges County Md.		
10. CITY OR TOWN OF DEATH Clinton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Maryland Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired	12b. KIND OF BUSINESS OR INDUSTRY Postal Service	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Pr. George 13c. CITY OR TOWN Oxon Hill					
14. FATHER'S NAME FIRST MIDDLE LAST Edward C. Malarkey		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Agnes McKeon			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes WWII		16b. SOCIAL SECURITY NO. 577-09-0892		17. INFORMANT ADDRESS Anna V. Malarkey same as item 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septic Shock DUE TO, OR AS A CONSEQUENCE OF (b) Leuwerx's lymphoma DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day 7 mos
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NO! WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from Sept 19 84 to April 19 85, that (I) (we) last saw the deceased alive on 4-19-19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Kas-Yin YEUNG MD		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4-19-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Kas-Yin YEUNG MD		22e. ADDRESS 8926 Woodyard Rd #201 Clinton Md 20735			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 4/23/85	23c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Clinton P.G. Md.	
24. FUNERAL DIRECTOR NAME G.P. Kalas 6160 Oxon Hill Rd. Oxon Hill, Md.		25a. DATE REC'D. BY REGISTRAR APR 24 1985		25b. REGISTRAR'S SIGNATURE John Swenson-Rendall	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

120074



101036

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 5	1 2 3 4 6
1. DECEASED NAME (TYPE OR PRINT) EUGENE FRANCIS MARLEY		2a. DATE OF DEATH MONTH DAY YEAR April 1, 1985		2b. HOUR 2:03pm	
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR June 11 1935		6. AGE (IN YEARS LAST BIRTHDAY) 49	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S CO. MD.	
10. CITY OR TOWN OF DEATH LANDAM	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DOCTORS' HOSPITAL of P.G. CO.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Salesman-Disabled		12b. KIND OF BUSINESS OR INDUSTRY Cemetery
13a. STATE Maryland	13b. COUNTY Prince George	13c. CITY OR TOWN Hillcrest Hgt	13d. STREET ADDRESS / ZIP CODE 2825 Bellbrook St. 20748		
14. FATHER'S NAME Matthew	15. MOTHER'S NAME Marley	16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			
16a. SOCIAL SECURITY NO. 206-26-4626		17. INFORMANT ADDRESS Margaret M. Morgan 2825 Bellbrook St. Hillcrest Heights, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) massive pulmonary embolus DUE TO, OR AS A CONSEQUENCE OF (b) Chlamydia of esophagus (Post resection) DUE TO, OR AS A CONSEQUENCE OF (c) Thrombophlebitis of pelvis					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: None					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		19c. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		20c. HOW INJURY OCCURRED (LIMITED TO HOW INJURY OCCURRED IN PART I OR PART 2)	
21a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21c. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from March 1985 to 4-1-1985 that (I) (we) last saw the deceased alive on 4-1-1985 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Bahram Erfan		DEGREE MD		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BAHRAM ERFAN, MD		22e. ADDRESS 6510 Kenilworth Ave., Suite 2500 Riverdale, Maryland 20737			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/6/85		23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Wilkes Barre Luzerne Penn.		24. FUNERAL DIRECTOR NAME George P. Kalas Funeral Home			
25a. DATE REC'D. BY REGISTRAR APR 8 1985		25b. REGISTRAR'S SIGNATURE Lina Davidson-Randall			

101030

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove (tear) pages 1 and 2 and file within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					1 2 3 4 9 REG. NO.				
1. FOR STATE REGISTRAR					2a. DATE OF DEATH MONTH DAY YEAR 7b. HOUR				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Bertha Virginia MARGGRAF					March 19, 1985 8:45 P.M.				
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Oct. 4, 1904		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.		7. UNDER 1 YEAR 8. UNDER 24 HRS.	
7a. BIRTHPLACE (COUNTRY) Unknown		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD.			
10. CITY OR TOWN OF DEATH Riverdale		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Eugene Heinz Memorial				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary-D.C. Public Schools		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY Prince George		13c. CITY OR TOWN Riverdale		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 11411 Brown Rd 20772	
14. FATHER'S NAME FIRST MIDDLE LAST Charles Marggraf				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 579 60 7597		17. INFORMANT ADDRESS Ella Haney 212 Kentucky Ave SE Washington, DC 20003			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio pulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Sepsis DUE TO, OR AS A CONSEQUENCE OF (c) Renal Failure								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 minute 3 days 1 week	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Pneumonia, basal, bilateral									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) this hospital attended the deceased from January 31, 1983, to March 19, 1985, that (I) lost saw the deceased alive on March 19, 1985, and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) see (did) not view the body after death.									
22b. SIGNATURE Walcutt W Gibson M.D.						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3-19-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Walcutt W GIBSON, M.D.						22e. ADDRESS 4300 St. Barnabaz Road Marlow Heights, Md., 20748			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 27 March 85		23c. NAME OF CEMETERY OR CREMATORY Lee Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Washington, DC		
24. J. William Lee's Sons Co. 300 4th St. NE Washington, D.C. 20002						25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE APR 0 3 1985 Julia Davidson-Rodella			

BP

101086

Unknown

United States

Secretary - U.S. Office of Economic Affairs

The Joint Information

Unknown

212 West 10th St
Washington, D.C. 20005

BY Order of the Secretary

U.S. Office of Economic Affairs

Washington, D.C. 20005

102114

 STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH

REG. NO.

 1- FOR
 STATE
 REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) John Joseph Mattras			2a. DATE OF DEATH April 8, 1985			2b. HOUR 3:40 AM				
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR July 10, 1933		6. AGE (IN YEARS LAST BIRTHDAY) 51 YRS.		7. UNDER 1 YEAR MONTHS DAYS 1 MONTHS 0 DAYS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges County MD.				
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince Georges General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Attorney		12b. KIND OF BUSINESS OR INDUSTRY US Government		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Pr Goerge's		13c. CITY OR TOWN Bowie		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 12620 Milburn Lane 20715	
14. FATHER'S NAME FIRST MIDDLE LAST Peter Mattras			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Basiaga			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				
16b. SOCIAL SECURITY NO. 194-26-8644			17. INFORMANT Paula M. Mattras			17. ADDRESS 12620 Milburn Lane Bowie, Maryland 20715				

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gastrointestinal Bleeding DUE TO, OR AS A CONSEQUENCE OF (b) Esophageal varices DUE TO, OR AS A CONSEQUENCE OF (c) Cryptogenic cirrhosis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days 3 years 5 years
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **no**

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 4:17 P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 3/13 1980 to 4/8 1985 , that (I) (we) lost saw the deceased alive on 4/7 1985 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) see the body after death.							
22b. SIGNATURE Leonard P. Appel				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/8/85	
22d. REGISTRAR'S NAME (TYPE OR PRINT) Dr. Leonard P. Appel, M. D.				22e. ADDRESS 3231 Superior Lane Bowie, Maryland 20715			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE April 11, 1985		23c. NAME OF CEMETERY OR CREMATORY St. John's Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring, Montgomery, MD	
24. FUNERAL DIRECTOR NAME Beall Funeral Home		16000 Annapolis Rd Bowie, MD 20715		25. DATE REC'D. BY REGISTRAR APR 9 1985		25b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

John	Joseph	Thomas	April 8, 1978	3:40 PM
Male	Canadian	July 10, 1933	FI	
Chesapeake	USA	Prince Georges County		
Chesapeake	Prince Georges General Hospital	Attorney		US Government
Chesapeake	Dr. George's House	12000 Williams Lane	20115	
Chesapeake	Chesapeake	Chesapeake		
10	101-20-0000	Paula A. Nettles	Chesapeake, Maryland	20115

[Faint, illegible handwritten notes and signatures across the middle of the page.]

10000 Annapolis Rd.	April 11, 1978	Dr. Joseph P. Taylor, M.D.	3231	Chesapeake, Maryland
10000 Annapolis Rd.	April 11, 1978	Dr. Joseph P. Taylor, M.D.	3231	Chesapeake, Maryland

109104

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF AN AUTOPSY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, 3 AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN THE DIVISION OF VITAL RECORDS, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

I. DECEASED NAME (TYPE OR PRINT)			FIRST JAMES			MIDDLE FRANKLIN			LAST McCHESNEY Jr.			2b. DATE KNOWN OF DEATH ESTIMATED 4-5-85 19 85			2c. DATE OF DEATH MONTH DAY YEAR 4-5-85 19 85			2d. HOUR 2:48a		
4. RACE Male			5. DATE OF BIRTH MONTH DAY YEAR 3 31 34			6. AGE (IN YEARS) (LAST BIRTHDAY) 51 YRS.			IF UNDER 1 YR. MONTHS DAYS HOURS MIN.			7c. DATE PRONOUNCED DEAD DOH 4-5-85 19 85			7d. HOUR A M					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna.			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD.											
10. CITY OR TOWN OF DEATH LANHAM			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DOCTORS' HOSPITAL of P.G. Co.									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Elec. Tech.			12b. KIND OF BUSINESS OR INDUSTRY U.S. Govern.					
13a. STATE Maryland									13b. COUNTY P.G.			13c. CITY OR TOWN SEABROOK			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 20801 9700 Franklin Ave		
14. FATHER'S NAME FIRST MIDDLE LAST James F McChesney Sr						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Carolyn Myers														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO						16b. SOCIAL SECURITY NO. 579-42-0892			17. INFORMANT ADDRESS Rose M McChesney same as #13											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pulmonary cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a.																				
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH						21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19						21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>						21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)						21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																				
ACTUAL SIGNATURE <u>Augusto P. Rodriguez</u>						TITLE (SPECIFY) Deputy						MEDICAL EXAMINER DATE SIGNED 4-5-85								
EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez, M.D.						ADDRESS 5009 Rayburn Ct., Temple Hills, Md														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial						23b. DATE 4/8/85			23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery						23d. LOCATION CITY OR TOWN COUNTY STATE Suitland PG MD					
24. FUNERAL DIRECTOR NAME ADDRESS Robert E Wilhelm Funeral Home Suitland MD																				

APR 15 1985
DATE REC'D BY REGISTRAR
REGISTRAR'S SIGNATURE
John Davidson-Randall

